

Centers For Medicare & Medicaid Services

Approved Renewal Waiver

Nursing Facility

A and B Level of Care

Control Number: 0139.90

for

Medicaid Reimbursement

of

Home and Community-Based Services

January 1, 2002 – December 31, 2006

To the Secretary

of the

United States Department of Health and Human Services

In accordance with

Section 1915(c) of the Social Security Act

**Nursing Facility Level A and B
Home and Community-Based Services Waiver
Control Number 0139.90**

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SECTION 1915(c) WAIVER FORMAT

1. The State of California (State) requests a Medicaid home and community-based services (HCBS) waiver under the authority of Section 1915(c) of the Social Security Act (Act). The administrative authority under which this waiver will be operated is contained in Appendix A.

This is a request for a model waiver.

a. _____ Yes b. X No

If yes, the State assures that no more than 200 individuals will be served by this waiver at any one time.

This waiver is requested for a period of (check one):

a. 3 years (initial waiver)

b. X 5 years (renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following level(s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

a. X Nursing facility (NF), NF-A and NF-B level of care

b. ____ Intermediate care facility for mentally retarded or persons with related conditions (ICF/MR)

c. _____ Hospital

d. ____ NF (served in hospital)

e. _____ ICF/MR (served in hospital)

3. A waiver of Section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

a. _____ aged (age 65 and older)

b. X disabled

c. _____ aged and disabled

d. _____ mentally retarded

e._____ developmentally disabled

f. mentally retarded and developmentally disabled

g. ____ chronically mentally ill

4. A waiver of Section 1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):

a. ____ Waiver services are limited to the following age groups (specify):

b. ____ Waiver services are limited to individuals with the following disease(s) or condition(s)

(specify):

c. ____ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.

d. X Other criteria. (Specify):

The following additional criteria will be used to limit individuals who will receive services under the waiver:

This waiver will serve physically disabled Medi-Cal beneficiaries for whom, in the absence of this waiver, and as a matter of medical necessity, pursuant to Welfare and Institutions (W&I) Code, Section 14059, would otherwise require care in an inpatient nursing facility providing the following types of care:

1. Nursing Facility Level A services, pursuant to Title 22, California Code of Regulations (CCR), Section 51120 and 51334 or
2. Nursing Facility Level B services, pursuant to Title 22, CCR, Section 51124 and 51335

for at least 365 consecutive days. In addition, all requests for Nursing Facility Level A and B Waiver services shall meet the criteria set forth in Title 22, CCR, Section 51344 (c), as appropriate.

Individuals served under this HCBS waiver will need to have an identified support network system to be available to them in the event the HCBS provider of care services is not able to provide the total number of authorized hours. The identified HCBS waiver service provider will assess for the availability of this support network system with the onset of services and periodically thereafter and no less than twice a year. In the event the beneficiary does not have this network system or if changes are needed, the HCBS provider of services will assist the beneficiary in developing and/or maintaining this support system. MCOI-IHO will also assist, as warranted, in the identification of supports needed to ensure the health and safety of the individual while under this waiver. To the extent that a support network care system cannot be

identified and/or implemented to ensure the health and safety of the individual, waiver services will not be authorized and the beneficiary will be notified in writing of their rights to appeal this determination.

Nursing Facility Level A and B (NF A/B) Waiver services will be provided in a beneficiary's or primary caregiver's own residence, which is not a licensed health facility. However, if the home setting is not medically appropriate or available, the place of residence may include congregate living situations or facilities licensed as congregate living health facilities-Type "A" (CLHF-A) pursuant to Title 22, CCR, Section 51173.1, or a specialized foster care home, pursuant to W&I Code, Section 1773.1.

To transition waiver recipients at the NF A and NF B level of care from the current NF waiver #0139.90.R1 into the new Nursing Facility NF A/B Waiver, the State will evaluate each recipient using the criteria that has been developed for this waiver as indicated in subsection 4 d, above. Continued Medi-Cal eligibility shall also be ascertained for the individual recipient. If it is determined that a recipient receiving services under the current NF waiver is ineligible for transition to the new NF A/B Waiver, the individual will be evaluated for a determination of appropriateness for transition to either the In-Home Medical Care Services (IHMC) Waiver or the NF Subacute (NF SA) Waiver. Any transition is conditioned on determination that an individual meets the specific criteria described in the respective waivers. If the individual is not eligible for any of the above mentioned waivers, MCOI-IHO staff will assist in providing the beneficiary with information on other available resources within the community including information on how to access the other available home and community-based service waivers within the Department.

e. Not applicable.

5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of this request.
6. This waiver program includes individuals who are eligible under medically needy groups.
 - a. X Yes
 - b. No
7. A waiver of Section 1902(a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy.
 - a. X Yes, only as explained in Appendix C-2-1.
 - b. No
 - c. N/A
8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.

a. ☒ Yes b. ☐ No

The beneficiary and, if appropriate, a beneficiary's representative will participate in the selection of available waiver services authorized in the Plan of Treatment (POT) utilizing the Menu of Home and Community-Based Services waiver service (MOHS) Form. (See attachment to Appendix D3). Selection shall include consideration of the services' current identified costs up to the amount described in Appendix G, as may be amended from time to time.

9. A waiver of the "statewideness" requirements set forth in Section 1902(a)(1) of the Act is requested.

a. ☐ Yes b. ☒ No

If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

10. A waiver of the amount, duration and scope of services requirements contained in Section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

11. The State requests that the following home and community-based services, as described and defined in Appendix B.1 of this request, be included under this waiver:

a. ☒ Case managementb. ☐ Homemakerc. ☐ Home health aide servicesd. ☒ Personal care servicese. ☒ Respite caref. ☐ Adult day healthg. ☐ Habilitation☐ Residential habilitation☐ Day habilitation☐ Prevocational services☐ Supported employment services☐ Educational servicesh. ☒ Environmental accessibility adaptations

- i. ☐ Skilled nursing
- j. ☐ Transportation
- k. ☐ Specialized medical equipment and supplies
- l. ☐ Chore services
- m. ☒ Personal Emergency Response Systems
- n. ☐ Companion services
- o. ☒ Private duty nursing *to include Home Health Aide services and shared nursing services*
- p. ☒ Family training
- q. ☐ Attendant care
- r. ☐ Adult Residential Care
- ☐ Adult Foster Care
- ☐ Assisted living
- s. ☐ Extended State plan services (Check all that apply):
- ☐ Home health care services
- ☐ Physical therapy services
- ☐ Occupational therapy services
- ☐ Speech, hearing and language services
- ☐ Prescribed drugs
- ☐ Other (specify):
- t. ☒ Other services (specify):
- Utility Coverage
 - Waiver Service Coordination
- u. ☐ The following services will be provided to individuals with chronic mental illness:
- ☐ Day treatment/Partial hospitalization

_____ Psychosocial rehabilitation

_____ Clinic services (whether or not furnished in a facility)

12. The State assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.
13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. The written plan of care/plan of treatment is to be developed prior to the delivery of the requested waiver services. MCOI-IHO will assist the HCBS waiver service provider in the development of the plan of care/plan of treatment as requested. All HCBS waiver service providers will be required to utilize the plan of care/plan of treatment developed by MCOI-IHO, which can also be found in the Attachments of Appendix E2 of this application. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency. Federal Financial Participation (FFP) will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services which are not included in the individual written plan of care.
14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.
15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):
- a. X When provided as part of respite care in a facility approved by the State that is not a private residence (~~hospital, NF, foster home, or community residential facility~~).
 - b. _____ Meals furnished as part of a program of adult day health services.
 - c. _____ When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

16. The Medicaid agency provides the following assurances to the Centers for Medicare and Medicaid Services (CMS).
- a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:

1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);
 2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and
 3. Assurance that all facilities covered by Section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.
- b. The agency will provide for an evaluation (and periodic reevaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The evaluations will be conducted by home visits made to the waiver beneficiary every six months. The requirements and the details for the home visits for such evaluations and reevaluations are detailed in Appendix D.
- c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:
1. Informed of any feasible alternatives under the waiver; and
 2. Given the choice of either institutional or home and community-based services.
- d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.
- e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.
- f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.
- g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.

- h. The agency will provide CMS annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by CMS.
- i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.

a. X Yes b. No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to CMS at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

a. Yes b. X No

18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

19. An effective date of January 1, 2002 is requested.

20. The State contact person for this request is Patricia Lof, Chief of the Long-Term Care Options Unit, Medi-Cal Rate Development Branch, who can be reached by telephone at (916) 653-4916.

21. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under Section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by CMS, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any

proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature: _____ (signed by) _____

Print Name: Gail L. Margolis, Esq.

Title: Deputy Director

Medical Care Services

Department of Health Services

Date: _____

APPENDIX A, ADMINISTRATION**LINE OF AUTHORITY FOR WAIVER OPERATION**

CHECK ONE:

- ☒ The waiver will be operated directly by the Medi-Cal Operations Division (MCOB), In-Home Operations (IHO) of the Department of Health Services (DHS), the Medicaid agency.
- ☐ The waiver will be operated by _____, a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.
- ☐ The waiver will be operated by _____, a separate division within the Single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

Appendix A, Monitoring and Oversight Plan**In-Home Operations****Home and Community-Based Services Waiver Monitoring Standards**

1. It is the primary objective of the Nursing Facility (NF) Level A and Level B (A/B) Waiver to provide Home and Community-Based Waiver Services (HCBS) to Medi-Cal beneficiaries who would otherwise reside in an institutional setting due to their chronic medical care needs. As a basis for providing services in the home setting, the home must be determined safe for the delivery of waiver-based services.
2. Medi-Cal Operations Division (MCOD), Medical Care Coordination and Case Management Branch, In-Home Operations (IHO) oversees the implementation of the NF A/B Waiver services in the home for Medi-Cal beneficiaries, and determines if the services provided are appropriate, medically necessary, safe and cost neutral.
3. MCOI-IHO is responsible for the authorization of requested HCBS services and has no regulatory oversight for providers. All HCBS waiver providers will be required to sign the "Medi-Cal In-Home Operations Home and Community-Based Services (HCBS) Waiver Provider Agreement". The original signed document will be maintained in the beneficiary's MCOI-IHO chart.

The HCBS providers primarily utilized are currently enrolled Medi-Cal providers who meet applicable State and federal licensing or certification criteria. Licensing and/or certification is done by other entities within the Department of Health Services (DHS). As outlined in statute and regulation, the regulatory agencies conduct periodic assessment of the Medi-Cal provider. There are also providers who are licensed individuals but who are not traditional Medi-Cal providers. This would include licensed nurses. These individuals are regulated based upon standards of practice and licensure status. MCOI-IHO has established relationships with the licensing entities and collaborate with them as needed in the event problems arise involving the delivery of services for which the provider is licensed or certified to render. This collaboration includes identifying key contacts within these departments to call for questions or concerns regarding the delivery of services, information for filing reports of inadequate care and having the reports sent to MCOI-IHO based upon filed complaints made by either MCOI-IHO and/or the beneficiary.

MCOI-IHO has statewide responsibility for training providers in terms of the HCBS waiver services. This training includes defining HCBS services, the available services under the waivers, provider enrollment activities, accessing the services for authorization, documentation requirements for authorization of services, general billing, eligibility information, record maintenance and findings from internal quality assurance activities as they relate to the delivery of HCBS waiver services. The training is determined either by direct requests or an identified need as determined by the IHO nurse case manager for new or existing providers. Training is primarily conducted by the MCOI-IHO Nurse Consultant staff but may also include program staff such as the nurse case managers, analysts, and eligibility liaisons. Through internal quality assurance activities, MCOI-IHO will also

assess for priority training issues i.e. those that impact the health and safety of the waiver beneficiary or the appropriate implementation of the waiver program. Based upon the findings, in-service training's will be developed and implemented which may be directed towards waiver service providers, beneficiaries and/or MCOD-IHO program staff.

Additionally, there is a certain percentage of Department approved providers that may be utilized for HCBS waiver services who are not licensed. These unlicensed individuals will receive training on providing appropriate services to the needs of the beneficiary within their delegated scope of practice per State code. This training can come from the primary care physician or medical team, which may include clinical staff from the primary care physician's office or other specialists, the beneficiary and/or his/her authorized representative and other licensed providers that may be rendering HCBS services. These licensed providers may include home health agencies, private duty nursing agencies or individual nurse providers. Additionally, program staff as listed above may assist in this training. The training will be based on the recipient's needs and knowledge, skills and abilities of the unlicensed provider. MCOD-IHO staff will also evaluate for the knowledge, skills, and abilities of the unlicensed caregiver. This will be done by asking the beneficiary about the training provided to the unlicensed caregiver; and the caregiver's and the beneficiary's ability to recognize adverse signs and symptoms requiring assessment and/or intervention of a licensed health care practitioner. This information will be documented accordingly on the IHO Intake Medical Summary (IMS) or the Case Management Report (CMR) form. Any issues identified with the delivery of services which impact the health and safety of the beneficiary will be reported to the primary care physician and to the appropriate law enforcement, child or adult protective services, as applicable.

4. As the individual case warrants and prior to rendering care, a waiver service provider must demonstrate that they either meet applicable State or federal license requirements associated with the provision of the identified services, or that they have been properly trained by appropriate individual(s) to administer such care.
5. Upon a determination that all requirements have been met in terms of medical necessity for services and that the home is a safe environment for the delivery of the services, the following is completed:
 - a. A "Freedom of Choice" document will be signed by each beneficiary or his/her authorized representative indicating that they were informed of the alternatives available to them and that it is their choice to either accept or decline HCBS waiver services. The original signed document will be maintained in the beneficiary's MCOD-IHO chart.
 - b. A "Menu of Home and Community-Based Services waiver service" (MOHS) document is completed with participation by the beneficiary and the MCOD-IHO nurse case manager and, if appropriate, the authorized representative, the primary physician, the provider(s) of service(s). The MOHS is used to identify the services that are available and their current assigned costs for waiver purposes. This collaboration enables the beneficiary to directly participate in the selection of the services that meet the identified and authorized needs of the beneficiary while helping to ensure overall cost neutrality of the waiver program.

- c. An "Informing Notice" is sent to the primary physician, the beneficiary or, if appropriate, the authorized representative and the provider of service indicating the roles and responsibility of each participant to ensure a successful, safe home program for waiver services. This notice also outlines the roles and responsibilities of the Department in the management of the waiver services. A copy of all of these letters will be maintained in the beneficiary's MCOD-IHO chart.
6. The following monitoring standards are employed by MCOD-IHO for:

Initial Evaluations

- a. All initial cases are evaluated by the MCOD-IHO Intake Unit, which is comprised of registered nurses. The Intake Unit is responsible for the review of documentation submitted by the primary care physician and the provider of service that supports the need for requested services. Documentation from related persons and entities is reviewed as warranted.
- b. Evaluations conform to regulatory and statutory requirements and guidelines for Medi-Cal and waiver services.
- c. Documentation to verify that the home environment is safe for the delivery of the requested nursing and related waiver services is included in documentation submitted by the provider of service.
- d. The provider, with input from the beneficiary and, if appropriate, the authorized representative and the MCOD-IHO nurse case manager develop an individualized plan of care/plan of treatment (POT), that is signed by the beneficiary or the authorized representative, the provider of service and the physician. The POT outlines the authorized waiver services to be provided in the home. Based on the MOHS, the provider incorporates into this plan the beneficiary's choice regarding overall delivery of waiver and related services, all in accordance with State and federal regulations.
- e. As warranted, the MCOD-IHO Intake Unit nurse will also make home visits to verify submitted information regarding the medical necessity of requested services and the safety of the home environment prior to the approval of case.
- f. In reviewing submitted documentation, any issues identified by the MCOD-IHO Intake nurse that may impact the appropriate and safe delivery of care are thoroughly evaluated. Issues may include such things as Medi-Cal eligibility, other insurance payer sources, Medi-Cal Managed Care enrollment, provider related issues, beneficiary and/or family related social issues, an inappropriate developed POT or MOHS, or a concern for home safety. The MCOD-IHO nurse works collaboratively with the beneficiary or the authorized representative, the provider(s) of service(s) and the physician to accurately identify and resolve such issues. Once the issues have either been resolved, or a plan is in place for resolution, the case is approved.
- g. All relevant information collected in the development of the home program for waiver services is documented on the IMS report and is maintained in the beneficiaries' MCOD-

IHO record. Additional information may also be found in the running record in the MCOD-IHO record.

- h. Upon final approval, the case is assigned to an MCOD/IHO nurse case manager, who is a registered nurse for ongoing case management.

Ongoing Case Management

- a. Ongoing case management is provided to ensure that the home program set up for the delivery of waiver services remains appropriate and medically necessary, that the home remains a safe environment for the beneficiary.
- b. Case Management includes overall management and follow-up on issues identified during the initial intake process and any new issues that arise subsequent to the approval of services. Activities include: routine home visits to the beneficiary at prescribed intervals described in the waiver; annual visits to the provider(s) of service(s); telephone contact with the physician as warranted; review of POT(s) and MOHS during on-site visits, upon any change in medical condition, or as additional services are requested; review and authorization of waiver and State Plan services according to state regulations; and, working with related persons and entities involved with the beneficiary's care.
- c. The waiver must be administered in accordance with federal regulations, which specify that the waiver program must be "cost neutral." The waiver program is cost neutral if the average per capita annual Medicaid expenditure under the waiver does not exceed the average per capita annual Medicaid expenditure absent the waiver. Monitoring of individual beneficiaries on a regular basis is necessary to help ensure continued and consistent waiver viability and cost neutrality.
- d. As issues are identified, the MCOD-IHO nurse case manager follows-up with the HCBS provider(s) of service(s), the physician, the beneficiary and, if appropriate, the authorized representative, for resolution.
- e. All plans developed to resolve identified problems are thoroughly evaluated by the MCOD-IHO nurse case manager to ensure that they are appropriate, will result in a resolution which is amenable to all, and will continue to meet the needs of the beneficiary.
- f. All contact made by the MCOD-IHO nurse case manager with a HCBS provider of service, the physician and the beneficiary related to identified problems will be noted in the MCOD-IHO chart.
- g. In addition to maintaining a record in the beneficiary's file, in the event significant incidents occur that involve the beneficiary while under the care of a provider, the provider shall submit written documentation to the MCOD-IHO nurse case manager for review.
- h. During scheduled or unscheduled home visits or provider visits any previously identified issue or incident will be followed-up in an appropriate manner. Identified issues will be

monitored and tracked accordingly through internal quality assurance activities. The goal is to track and follow-up on issues that may directly or indirectly affect health and safety of the individual while under the waiver program. Direct incidents pertain to the actual care received, which may impact the physical or psychological health and safety of the individual. Indirect incidents pertain to aspects of the individuals living environment which may indirectly impact the health and welfare of the individual such as lack of needed medical supplies or equipment or staff misconduct on behalf of the HCBS waiver service provider. Based upon the findings from these incidents will determine the appropriate action to be taken by MCOD-IHO and the subsequent follow-up. These incidents will be monitored and tracked on the "Complaint Event Record".

- i. The specific nature of an issue or incident will determine if notification of others is warranted. If a determination is made that other persons or entities should be notified, the provider of service will be given direction by the MCOD-IHO nurse case manager as to whom to contact and what documentation is required to be provided to MCOD-IHO.
- j. On-site visits made to the home of the beneficiary are documented on the CMR form and are maintained in the MCOD-IHO chart. Home visit evaluations include assessing the continued medical necessity for services, home safety, identification of problems with plans for correction and follow-up, identification of social services that may be available in the community, the review of home medical record which contains the nursing notes, POT's and the MOHS and the review of the cost neutrality of the program.
- k. Cost Neutrality will be evaluated by tracking the costs of authorized waiver and state plan services received by the beneficiary. HCBS waiver services and state plan services authorized by MCOD/IHO will be tracked on the MOHS. The total of the two types of costs must be less than the identified institutional alternative for the beneficiary. If requested services are not cost neutral, they will not be authorized.
- l. On-site visits made to a provider of service will be documented on a "HCBS Provider Visit" report. The report will include appropriate information on staffing issues, necessary POT revisions, necessary MOHS revisions, review of case management notes made by the provider and any issue(s) identified by the provider related to the home program for the beneficiary.

Personal Care Services

The Department of Social Services (DSS) operates and administers the Medi-Cal State Plan Personal Care Services Program (PCSP) through an interagency agreement with the Department. Following is a description of how the current PCSP operates, and how "Waiver Personal Care Services" are provided under the NF/AB Waiver as described, below.

Department of Social Services:

The In-Home Supportive Services (IHSS) or PCSP provider is hired by the Medi-Cal beneficiary and is the employee of that beneficiary. Any training needed is the responsibility of the beneficiary. No formal training exists or is required by DSS for IHSS or PCSP providers. However, depending on the county in which a beneficiary resides, their provider may receive

training as a component of the Supported Individual Provider services (23 counties) or under a Public Authority (seven counties). A Public Authority is required, by statute, to provide training to its provider population. Providers may also receive training if they are employed by a contract agency that serves IHSS or PCSP beneficiaries.

Monitoring of the IHSS and PCSP regulatory requirements is provided through DSS' Adult Programs Branch, Evaluation and Integrity Bureau. Counties are evaluated approximately every four years.

Individual county departments of social services are responsible for both the initial and annual assessments of the IHSS and PCSP beneficiaries, and for the monitoring of authorized hours to ensure that the services are being provided (up to a maximum approved 283 hours per month). County departments of social services are not responsible for the monitoring of any Waiver Personal Care Services authorized under the Medicaid waiver programs.

Department of Health Services – Medi-Cal Operations Division:

A beneficiary who receives Waiver Personal Care Services must meet the eligibility criteria for the NF A/B Waiver and must also be enrolled in the State Plan Personal Care Services Program. In addition, as part of the eligibility criteria for Waiver Personal Care Services only and to ensure health and safety, the beneficiary shall receive periodic case management visits from an identified waiver service case management provider, at prescribed intervals to be determined by the physician. As warranted, intermittent nursing services may be authorized through the State Plan benefit.

The beneficiary employing the unlicensed caregiver or the applicable county agency will serve as the supervisor of the Waiver Personal Care services provider.

If a Home Health Agency (HHA) or private duty nursing agency (PDNA) participates in the home care plan for the beneficiary but does not employ the personal care services provider, the HHA/PDNA nurse is not responsible for the monitoring or supervision of the personal care services provider when the beneficiary is receiving State Plan or Waiver Personal Care Services. However, the HHA/PDNA nurse is responsible for monitoring the health, safety, and welfare of the waiver beneficiary.

The HHA/PDNA nurse will be responsible for discussing with the beneficiary or authorized representative the beneficiary's health status and the care being provided. The HHA/PDNA nurse is required to report to child or adult protective services, or to the beneficiary's physician, depending on the situation, any areas of concern regarding a beneficiary, including any sign or symptom requiring professional evaluation or care.

If an individual nurse participates in the home care plan for the beneficiary, the individual nurse provider (INP) is not responsible for the monitoring or supervision of the personal care services provider when the beneficiary is receiving State Plan or Waiver Personal Care Services. However, the INP is responsible for monitoring the health, safety, and welfare of the waiver beneficiary. The INP will be responsible for discussing with the beneficiary or authorized representative the beneficiary's health status and the care being provided. The INP is required to report to child or adult protective services, or to the beneficiary's physician, depending on the

situation, any areas of concern regarding a beneficiary's health, safety and welfare, including any sign or symptom requiring professional evaluation or care.

Waiver Personal Care Services shall be rendered by a provider subject to the informed consent of the beneficiary or the authorized representative, which shall be obtained as a part of the order for service, pursuant to W&I Code 12300.1 and 14132.95. Additionally, the training requirements will be as previously outlined in section 3, above, with the primary responsibility being that of the beneficiary with support from the primary care physician and/or medical team, any identified nursing support and MCOI-IHO staff which would include the IHO nurse case manager, program analysts, eligibility liaisons and nurse consultant staff, as warranted.

In the event that there are no willing HCBS service providers to render the case management services or intermittent nursing services as allowed for under the State Plan benefit, the IHO nurse case manager will work with the beneficiary, the waiver personal care service provider and the physician in setting up the waiver home care program. The activities of the IHO nurse case manager would include obtaining initial assessments by conducting a home visit prior to the initiation of waiver services, conducting home visits every six months or more frequently as needed. The assessment will involve obtaining information from the beneficiary/family and documentation of a "review of systems" as indicated on the IHO Intake Medical Summary (IMS) or Case Management Report (CMR), as applicable. Additionally, the IHO nurse case manager would work collaboratively with the physician, the beneficiary and the waiver personal care service providers in developing and updating the plan of treatment, resolving or putting into place a plan of correction for issue resolution and reporting to the appropriate entities as needed for health and safety concerns.

To the extent that the waiver participant is willing and able, they will be allowed to manage their personal care services to the extent of their capability.

Establishment and Maintenance of a Waiting List

When the maximum number of recipients authorized for enrollment in the NF A/B's current year is reached, the Department will implement the following procedures to establish and maintain a waiting list of individuals eligible for potential enrollment in the NF A/B waiver program.

All inquiries received for placement on the waiting list will be added to the current waiting list based upon the date the inquiry is received in MCOI-IHO.

- Inquiries may be received by:
- Telephone calls from interested parties,
- Faxed information from interested parties,
- Treatment Authorization Request (TAR) or similar request, from a rendering provider (a TAR or similar request, is not required as a condition for placement on the waiting list).

To be placed on the waiting list, the following information must be provided to the MCOI-IHO Intake Unit:

- First and last name of the beneficiary
- Date of Birth of the beneficiary
- Social Security Number of the beneficiary
- Telephone number for follow-up on request
- Date of receipt of the request
- Person making the request if other than the beneficiary
- Completed HCBS waiver questionnaire for medical care needs

An entry into the MCOD-IHO database will be made with a status assignment of “W” to indicate they are on the waiting list, with applicable comments written in the “Comment Section” of the MCOD-IHO database.

Notification of the MCOD-IHO Eligibility Liaisons will be made to assess Medi-Cal eligibility for the NF A/B recipients. Eligibility assessments will include evaluations of “community deeming” or “institutional deeming” rules.

Evaluation of any TAR or similar request received will be done in accordance with the current procedure, referencing the applicable NF A/B Waiver cap. The fiscal intermediary or MCOD-IHO will generate a Notice of Action for the TAR or similar request indicating the NF A/B Waiver cap has been reached for the applicable calendar year. MCOD-IHO will also generate and mail the appropriate letter and the HCBS waiver questionnaire for medical needs to the provider and beneficiary describing the NF A/B Waiver cap and placement on the NF A/B waiting list.

If no TAR or similar request is received, MCOD-IHO will generate and mail the appropriate letter to the beneficiary and, if applicable, the provider, regarding the NF A/B Waiver cap and placement on the NF A/B waiting list.

The NF A/B waiting list will be maintained as long as MCOD-IHO has reached the applicable annual cap for enrollment of beneficiaries.

During any calendar year, for waiver slots made available due to the death of an existing waiver beneficiary, enrollment priority will be given to individuals receiving services under Early and Periodic Screening, Diagnosis and Treatment (EPSDT). To qualify for such priority, an individual must be currently receiving private duty nursing care under EPSDT, meet the criteria of the NF A/B waiver and attain 21 years of age during the calendar year. If additional waiver slots are available, cases will be moved off the waiting list. Records will be maintained by MCOD-IHO to identify the enrollment slot used to account for unduplicated beneficiaries above the approved annual enrollment cap.

At the beginning of each calendar year, a review of available waiver enrollment slots will be prepared. Other than slots which may be filled by EPSDT individuals having priority, as

described immediately above, the new enrollment slots allocated for any calendar year including any slots vacated due to loss of Medi-Cal eligibility, program withdrawal or other attrition, will be filled as follows:

Enrollment slots will be held available for those beneficiaries currently receiving services under the EPSDT program who will attain 21 years of age in the **new** calendar year.

Individuals on the waiting list will be contacted, in order of the date the initial request was received, to determine if they are still interested and meet NF A/B Waiver eligibility requirements. In the event several requests are received on any given day and it is determined that not all individuals will be accommodated on the waiver, the cases will be prioritized based on the month and day of birth, January being month one, starting with day 1 through the total number of days applicable to the appropriate month.

Individuals who are still interested and are eligible will be enrolled in the waiver by order of the date of the initial request, and until all enrollment slots are filled or the waiting list is exhausted, whichever occurs first.

STATE OF CALIFORNIA-HEALTH AND HUMAN SERVICES AGENCY

GRAY DAVIS, Governor

DEPARTMENT OF HEALTH SERVICES

700 NORTH TENTH STREET, SUITE 102

P. O. BOX 942732

SACRAMENTO, CA 94234-7320

(916) 324-1020



<DATE>

TO: BENEFICIARY NAME

BENEFICIARY ADDRESS

ETC.

Medi-Cal In-Home Operations (IHO) is ready to process your request for services for Home and Community-Based Services (HCBS) Nursing Facility Level A or Level B (NF A/B) Waiver. According to our current records, you do not have an identified HCBS waiver service provider.

Enclosed is a list of known HCBS waiver service providers in your area. You may contact one of these service providers, or others known to you, to determine if one of them is interested in providing HCBS waiver services to you in your home. You and the identified provider will need to contact our office **no later than <DATE (30 day standard time)>**, so that IHO may proceed in processing your request.

If there is no response from you or a service provider by <DATE>, your name will remain on the waiting list based upon original date of inquiry and IHO will proceed with contacting other individuals on the waiting list.

Should you have any questions regarding obtaining an HCBS waiver service provider or any information contained in this letter, please contact <Name, Title>, at <telephone number>.

Sincerely,

<Name, Title>

(BENEFICIARY WITHOUT SERVICE PROVIDER, REMAINING ON LIST)

STATE OF CALIFORNIA-HEALTH AND HUMAN SERVICES AGENCY

GRAY DAVIS, Governor

DEPARTMENT OF HEALTH SERVICES

700 NORTH TENTH STREET, SUITE 102

P. O. BOX 942732

SACRAMENTO, CA 94234-7320

(916) 324-1020



<DATE>

TO: BENEFICIARY NAME

BENEFICIARY ADDRESS

ETC.

Medi-Cal In-Home Operations (IHO) has received a request on your behalf for Home and Community-Based Services (HCBS) under the Nursing Facility Level A or Level B (NF A/B) Waiver. Per the call made to your home on <DATE>, you indicated you were no longer interested in pursuing services under the NF A/B Waiver. If you have reconsidered this decision, please contact the IHO Intake Unit at (916) 324-5903/5915. Enclosed with this letter is the "Freedom of Choice" document which indicates your choice to "Accept" or "Decline" Home and Community-Based Services waiver services.

The "Freedom of Choice" document requires your signature. Please sign and date as indicated and **return within five days** of receipt of this letter in the enclosed self-addressed envelope. Postage ***is not*** included, so please make sure you affix the proper postage amount. This document will be kept in your files at the designated IHO office. It is suggested that you make a copy for yourself prior to mailing this document back to IHO.

If IHO has had no response from you by <DATE (2wk standard time)> your name will be removed from the waiting list and the program will proceed with contacting other individuals on the waiting list. Please know you are welcome to contact the Intake Unit at (916) 324-5903/5915 with any questions.

Sincerely,

<Name, Title>

(BENEFICIARY REFUSES WAIVER SERVICES, NAME REMOVED FROM LIST)

STATE OF CALIFORNIA-HEALTH AND HUMAN SERVICES AGENCY

GRAY DAVIS, Governor

DEPARTMENT OF HEALTH SERVICES

700 NORTH TENTH STREET, SUITE 102

P. O. BOX 942732

SACRAMENTO, CA 94234-7320

(916) 324-1020



<DATE>

TO: BENEFICIARY NAME

BENEFICIARY ADDRESS

ETC.

Medi-Cal In-Home Operations (IHO) has received a request on your behalf for Home and Community-Based Services under the Nursing Facility Level A or Level B (NF A/B) Waiver. Please be advised that all waivers have a limit as to the number of people who can receive services during the calendar year. IHO is in the process of reviewing cases that were placed on a waiting list from <date>. Those requests determined to be eligible for waiver requests services will be approved during the <XXXX-XX> calendar year until the maximum enrollment is reached. However, there may not be sufficient waiver slots available for all of the pending applicants.

Referrals for the NF A/B Waiver services are evaluated on a first-come, first-served basis. At the time your referral is ready to be reviewed, IHO will contact you to determine your continued interest in being considered for these services. As a reminder, you may have access to other Medi-Cal State Plan Services through the appropriate Medi-Cal Field Office. Enclosed with this letter is a questionnaire that needs to be completed and returned to our office. This questionnaire will assist in determining your medical eligibility for the NF A/B waiver.

Should you have any questions regarding this letter, please contact <Name, Title>, at <telephone number>.

Sincerely,

<Name, Title>

(ANY NEW REFERRAL, NAME ON WAITING LIST)

APPENDIX B, SERVICES AND STANDARDS**Appendix B-1, Definition of Services**

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

a. X Case Management:

- X Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State Plan services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. These services are provided in cooperation with the Department of Health Services (DHS), Medi-Cal Operations Division (MCOD).

Because the primary needs of the NF A/B recipient are medical in nature, it is generally preferable in terms of managing the overall health and safety of the beneficiary to have the case management function performed by a person with a medical based background. However, there may be occasions where the beneficiary chooses to have their case manager be a person who is a Marriage, Family and Child Counselor (MFCC), Clinical Psychologist or Licensed Clinical Social Worker (LCSW), or an entity who employs such persons. Therefore, if appropriate, the following persons may provide case management services:

1. A Registered Nurse (RN) employed by a home health agency (HHA);
2. A RN employed by a Private Duty Nursing Agency (PDNA)
3. A RN, also known as an Individual Nurse Provider (INP), under the direction of a licensed physician;
4. An individual who is licensed and certified by the State of California such as MFCC, Clinical Psychologist, or LCSW; or
5. An entity or organization that is licensed and certified by the State of California to provide the services of a MFCC, Clinical Psychologist, or LCSW.

Case managers, described above, shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care/plan of treatment (POT) and Menu of Home and Community-Based Services Waiver Service (MOHS) Form.

1. X Yes 2. No

The waiver service providers for case management will have responsibility for the ongoing, routine aspects of waiver services being provided in the home. Waiver service providers will have the direct contact with the beneficiary and, as applicable, the assigned nursing staff and the physician. Waiver service providers will oversee the implementation and evaluation of all services identified in the POT and offered in the MOHS. Case management responsibilities include assessing, care planning, authorizing, locating, coordinating and monitoring a package of long-term care services for community-based clients. These services may be provided by an entity or organization of trained professionals or by a State licensed individual provider.

Case management services may begin up to 180 days prior to discharge from an institution. All services provided will be billed against the waiver on the date of discharge. If the beneficiary should decease before discharge, all services provided may be charged to the waiver on the date of death.

Case managers employed by DHS-MCOD shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care and MOHS at such intervals as are specified in Appendices D & E of this request.

1. X Yes

2. No

The “case management” to be provided by MCOD staff is primarily administrative in nature and will consist of such things as monitoring to help ensure the services provided by the waiver service provider are in accord with State and federal guidelines. The initial and ongoing assessment of Level of Care (LOC), review of the POT, and review of the MOHS are included in the monitoring activities.

MCOD case managers will provide for utilization review of authorized State Plan and waiver services as outlined in Title 22, California Code of Regulations (CCR), Section 51003. MCOD case managers will also be responsible for routine follow-ups with the waiver service case manager to:

1. Determine whether the authorized waiver services are appropriate and meet the identified needs of the beneficiary;
2. Ensure LOC determinations are accurate;
3. Identify, resolve, or ensure a plan is in place for resolution of issues affecting the beneficiary;
4. Review and authorize requests for waiver services and appropriateness of State Plan services as indicated in the POT/ MOHS; and
5. Review the cost neutrality of the program.

MCOD case management will be accomplished through the use of regular telephone contact with the waiver service case manager, home visits to the beneficiary, and yearly, or more frequent as appropriate, provider case conferences.

_____ Other Service Definition (Specify):

b. _____ Homemaker:

_____ Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

_____ Other Service Definition (Specify):

c. _____ Home Health Aide services:

_____ Services defined in 42 CFR 440.70, with the exception that limitations on the amount, duration and scope of such services imposed by the State's approved Medicaid plan shall not be applicable. The amount, duration, and scope of these services shall instead be in accordance with the estimates given in Appendix G of this waiver request. Services provided under the waiver shall be in addition to any available under the approved State Plan.

_____ Other Service Definition (Specify):

d. X Personal care services:

 X Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. This service includes hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by law. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care/plan of treatment, this service may also include such housekeeping chores as bedmaking, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

1.a. Services provided by family members (Check one):

_____ Payment will not be made for personal care services furnished by a member of the individual's family.

- X Personal care providers may be members of the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or stepparent), or to an individual by that person's spouse.

Justification attached. (Check one):

- X Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual.

 Standards for family members providing personal care services differ from those for other providers of this service. The different standards are indicated in Appendix B-2.

b. Services provided by Home Health Agency staff.

c. Services provided by Service Agencies employing personal care providers.

2. Supervision of personal care providers will be furnished by (Check all that apply):

 A registered nurse licensed to practice nursing in the State.

 A licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law.

 X Case managers as described in subsection B-1.a.

 X Other (Specify): The beneficiary employing the unlicensed caregiver/service agency or the applicable county agency will serve as the supervisor of the waiver personal care services provider.

If a Home Health Agency (HHA) or private duty nursing agency (PDNA) participates in the home care plan for the beneficiary but does not employ the personal care services provider, then the HHA/PDNA nurse is not responsible for the monitoring or supervision of the personal care services provider when the beneficiary is receiving State Plan or Waiver Personal Care Services. However, the HHA/PDNA nurse is responsible for monitoring the health, safety, and welfare of the waiver beneficiary. In this regard, the HHA/PDNA nurse discusses with the beneficiary their health and the care being provided. The HHA/PDNA nurse is required, depending on the circumstances, to report to Adult Protective Services, Child Protective Services or to the beneficiary's physician, any areas of

concern regarding a beneficiary's health, safety and welfare, including any sign or symptom requiring professional evaluation or care.

If an individual nurse provider (INP) participates in the home care plan for the beneficiary, then the INP is not responsible for the monitoring or supervision of the personal care services provider when the beneficiary is receiving State Plan or Waiver Personal Care Services. However, the INP is responsible for monitoring the health, safety, and welfare of the waiver beneficiary. In this regard, the INP discusses with the beneficiary their health and the care being provided. The INP is required, depending on the circumstances, to report to Adult Protective Services, Child Protective Services or to the beneficiary's physician, any areas of concern regarding a beneficiary's health, safety and welfare, including any sign or symptom requiring professional evaluation or care.

Waiver personal care services shall be rendered by a provider subject to the informed consent of the beneficiary or the authorized representative, and shall be obtained as a part of the order for service, pursuant to W&I Code sections 12300, et seq., and 14132.95. Additionally, the training requirements will be as previously outlined with the primary responsibility being that of the beneficiary with support from the primary care physician and/or medical team, any identified nursing support and MCOI-IHO staff which would include the IHO nurse case manager, program analysts, eligibility liaisons and nurse consultant staff, as warranted.

In the event that there are no willing HCBS service providers to render the case management services or intermittent nursing services as allowed for under the State Plan benefit, the IHO nurse case manager will work with the beneficiary, the waiver personal care service provider and the physician in setting up the waiver program. The activities of the IHO nurse case manager would include obtaining initial assessments by conducting a home visit prior to the initiation of waiver services, conducting home visits every six months or more frequently as needed. Additionally, the IHO nurse case manager would work collaboratively with the physician, the beneficiary and the waiver personal care service providers in developing and updating the plan of treatment, resolving or putting into place a plan of correction for issue resolution and reporting to the appropriate entities as needed for health and safety concerns.

To the extent that the waiver participant is willing and able, they will be allowed to manage their personal care services to the extent of their capability.

As part of the eligibility criteria for waiver personal care services only, the beneficiary shall receive periodic nurse case management visits from a RN, at prescribed intervals to be determined by the physician to ensure

health and safety. As warranted, intermittent nursing services will be authorized through the State Plan benefit.

Personal care service providers may be paid while the beneficiary is hospitalized up to 7 days per each hospitalization. This payment is necessary to retain the care provider for services when the beneficiary returns home. During these time periods, the personal care services provider will provide written documentation to MCO/D/IHO as to the activities performed. Appropriate activities may include care and maintenance of the home environment, running errands for the beneficiary which will facilitate the return home and checking mail.

3. Frequency or intensity of supervision (Check one):

 X As indicated in the plan of care/plan of treatment.

 Other (Specify):

4. Relationship to State Plan services (Check one):

 Personal care services are not provided under the approved State Plan.

 Personal care services are included in the State Plan, but with limitations. The waiver service will serve as an extension of the State Plan service, in accordance with documentation provided in Appendix G of this waiver request.

 X Personal care services under the State Plan differ in service definition or provider type from the services to be offered under the waiver.

 X Other Service Definition (Specify):

Personal care companions to provide non-medical care, supervision and socialization provided to a functionally impaired adult. Personal care companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The personal care companion may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

e. X Respite care:

_____ Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

 X Other service definition (Specify):

Intermittent or regularly scheduled temporary medical care and supervision provided in the beneficiary's own home or in an approved out-of-home location to do all of the following:

1. Assist family members in maintaining the beneficiary at home;
2. Provide appropriate care and supervision to protect the beneficiary's safety in the absence of family members;
3. Relieve family members from the constantly demanding responsibility of caring for a beneficiary; and
4. Attend to the consumer's medical needs and other activities of daily living, which would ordinarily be performed by the service provider or family member.

Federal Financial Participation (FFP) will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite care will be provided in the following location(s) (Check all that apply):

 X Individual's home or place of residence

_____ Foster home

_____ Medicaid certified Hospital

 X Medicaid certified NF A or B facility

_____ Medicaid certified ICF/MR

_____ Group home

_____ Licensed respite care facility

_____ Other community care residential facility approved by the State that its not a private residence

_____ (Specify type):

_____ Other service definition (Specify):

f. ____ Adult day health:

____ Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services.

(Check one):

1. ____ Yes

2. ____ No

____ Other service definition (Specify):

Qualifications of the providers of adult day health services are contained in Appendix B-2.

g. ____ Habilitation:

____ Services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

____ Residential habilitation: assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Documentation which shows that Medicaid payment does not cover these components is attached to Appendix G.

____ Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-

residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

____ Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving, and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs). Prevocational services are available only to individuals who have previously been discharged from a SNF, ICF, NF, or ICF/MR.

Check one:

____ Individuals will not be compensated for prevocational services.

____ When compensated, individuals are paid at less than 50 percent of the minimum wage.

Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

____ Educational services, which consist of special education and related services as defined in sections (15) and (17) of the Individuals with

Disabilities Education Act, to the extent to which they are not available under a program funded by IDEA. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, NF, or ICF/MR at some prior period.

— Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for vocational training that is not directly related to an individual's supported employment program.

____ Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

1. ____ Yes

2. ____ No

____ Other service definition (Specify):

The State requests the authority to provide the following additional services, not specified in the statute. The State assures that each service is cost-effective and necessary to prevent institutionalization. The cost neutrality of each service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

h. X Environmental accessibility adaptations:

X Those physical adaptations to the home, required by the individual's plan of care/plan of treatment and selected in the MOHS, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

All environmental modification services are subject to prior authorization by the DHS-MCOD nurse case manager. Requests for prior authorization for any and all modifications to a residence which is not the property of the waiver recipient shall be accompanied by written consent from the property owner for the requested modifications. Environmental modification services are payable one time only to a maximum amount of \$5,000.

The only exceptions to the one time, \$5,000 maximum are if:

1. The recipient's place of residence changes; or
2. In the opinion of the DHS-MCOD nurse case manager, and based upon review of appropriate documentation, the waiver beneficiary's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare and safety of the beneficiary, or are necessary to enable the

beneficiary to function with greater independence in the home and without which, the recipient would require institutionalization.

Absent written authorization from the owner, environmental accessibility modifications will not be authorized or be subject to compensation for residential care providers or rental units. To the extent possible, modifications will be made to the residence prior to occupation by the beneficiary. Upon commencement of the modification, all parties will receive written documentation that the modifications are permanent, and that the State is not responsible for removal of any modification if the beneficiary cease to reside at a residence which is rental property.

All requests for environmental accessibility modifications submitted by a provider should include the following information:

1. Physician's order specifying the requested equipment or service;
2. Physical Therapy evaluation and report to assess the medical necessity of the requested equipment or service. This should typically come from an entity with no connection to the provider of the requested equipment or service. The Physical Therapy evaluation and report should contain at least the following information:
 - a. An assessment of the beneficiary and the current equipment needs specific to the individual, describing how/why the current equipment does or does not meet the needs of the beneficiary.
 - b. An assessment of the requested equipment or service and description how/why it is necessary for the beneficiary. This should include the ability of the beneficiary and/or the primary caregiver to learn about and appropriately use any requested item.
 - c. Description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the beneficiary and a description of the inadequacy.
3. Medical Social Worker evaluation and report to assess for other community resources available to provide the requested equipment or service, the availability of the other resources, and any other pertinent recommendations related to the requested equipment or service. This should include the description of the availability of Other Health Care (OHC) coverage to provide for the requested equipment or service.
4. Depending on the type of adaptation or modification requested, documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the beneficiary, including any supporting documentation describing the efficacy of the equipment. Brochures will suffice in showing the

purpose and efficacy of the equipment; however, a brief written evaluation specific to the beneficiary will still be necessary describing how and why the equipment or service meets the needs of the individual.

5. If possible, include a minimum of **two bids** from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties.
6. The MCO nurse case manager will take the appropriate action on the TAR after all requested documentation has been received, reviewed, and a home visit has been conducted by appropriate program staff to determine the suitability of any requested equipment or service.

Because of the maximum allowed cost of \$5,000 for an adaptation, the use of this service will necessarily result in a reduction in the amount of other services the beneficiary may receive in the year the adaptation is authorized. Since the waiver must remain cost neutral, it is very important that the fiscal impact of this service be clearly understood by the beneficiary at the time of request for the accessibility adaptation and before the authorization of the modification service,

_____ Other service definition (Specify):

i. _____ Skilled nursing:

_____ Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

_____ Other service definition (Specify):

j. _____ Transportation:

_____ Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State Plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized.

_____ Other service definition (Specify):

k. _____ Specialized Medical Equipment and Supplies:

- _____ Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

- _____ Other service definition (Specify):

l. _____ Chore services:

- _____ Services needed to maintain the home in a clean, sanitary, and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

- _____ Other service definition (Specify):

m. X Personal Emergency Response Systems (PERS)

- X PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

PERS is a 24-hour emergency assistance service which enables the beneficiary to secure immediate assistance in the event of an emotional, physical, or environmental emergency. PERS are individually designed to meet the needs and capabilities of the beneficiary and includes training, installation, repair, maintenance, and response needs. The following types are allowed:

1. 24-hour answering/paging;
2. Beepers;
3. Med-alert bracelets;
4. Intercoms;
5. Life-lines;
6. Fire/safety devices, such as fire extinguishers and rope ladders
7. Monitoring services
8. Light fixture adaptations (blinking lights, etc.);
9. Telephone adaptive devices not available from the telephone company;
10. Other electronic devices/services designed for emergency assistance.

By providing immediate request for or access to assistance, PERS services prevent institutionalization of a waiver beneficiary. PERS services will only be provided as a waiver service to a beneficiary residing in a non-licensed environment.

All types of PERS, described above, shall meet applicable standards of manufacture, design, and installation. Repairs to and maintenance of such equipment shall be performed by the manufacturer's authorized dealers whenever possible. The cost effectiveness of this service is demonstrated in Appendix G. Prior authorization for PERS services must be obtained by the DHS approved waiver service provider from the designated Medi-Cal office.

_____ Other service definition (Specify):

n. _____ Companion services:

_____ Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

_____ Other service definition (Specify):

o. X Private duty nursing:

- X Individual and continuous care (in contrast to part time or intermittent care) provided by a licensed and certified home health agency (HHA), a private duty nursing agency (PDNA), a Congregate Living Health Facility-Type "A" (CLHF-A), a certified home health aide (CHHA) under a HHA, or individual licensed nurses within the scope of State law. These services are provided to an individual at home.

Shared Private Duty Nursing Services

"Shared Private Duty Nursing Services" under the waiver are provided by a licensed RN, LVN, or CHHA under a HHA, PDNA, an INP, or a CLHF-A in accordance with the attending physician's orders, the written plan of care/plan of treatment and the MOHS. Shared nursing is the provision of nursing services for two beneficiaries who live in the same residence and share a nurse amongst themselves, i.e., one nurse for two beneficiaries. This service will only be provided upon request by the beneficiary or his/her authorized representative.

Shared nursing services will be provided as private duty nursing services and defined in this section o., in units of one hour and will include a description of the practitioner's skill level (e.g., shared nursing – Registered Nurse; shared nursing – Licensed Vocational Nurse; shared nursing – Certified Home Health Aide).

____ Other service definition (Specify):

p. X Family training:

- X Training and counseling services for the families of individuals served on this waiver. For purposes of this service "family" is defined as:

1. The persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws, and
2. May include other responsible persons who agree to act as an uncompensated caregiver in the absence of a waiver service provider.

"Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home. All family training must be included in the individual's written plan of care/plan of treatment.

Family training services shall be rendered by a Registered Nurse. Pursuant to California statute governing RN's (Business and Professions Code, Division 2, Chapter 6, Section 2727) and LVN's (Business and Professions Code, Division 2, Chapter 6.5, Section 2861), gratuitous nursing by family members is not prohibited as long as these individuals are not in any way assuming practice as a professionally registered or licensed vocational nurse. Family

training will initially be carried out jointly by the physician and the provider of service. If the beneficiary's physician, provider of services or the IHO Nurse Case manager in consultation with the physician and provider of services determines that additional family training is required, it will be provided by the provider of service with appropriate documentation of the training rendered. The MCO staff will review training and its appropriateness on a case by case basis and will include follow-up on training for all beneficiaries and their families during scheduled on-site visits to the home.

Under certain circumstances there may be times when the nursing care services provider is unable to provide the total number of authorized hours. In the event this occurs, the back-up system for care should be implemented. The identified individuals who will participate in this back-up system for the care needs of the beneficiary should have received the appropriate supportive training. Training of family and provision of nursing care services by family members as warranted shall be identified on the physician-approved POT.

_____ Other Service Definition (Specify):

q. _____ Attendant care services:

_____ Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity.

Supervision (Check all that apply):

_____ Supervision will be provided by a Registered Nurse licensed to practice in the State. The frequency and intensity of supervision will be specified in the individual's written plan of care.

_____ Supervision may be furnished directly by the individual, when the person has been trained to perform this function, and when the safety and efficacy of consumer-provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on direct observation of the consumer and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained in the beneficiary's individual plan of care.

_____ Other supervisory arrangements (Specify):

_____ Other Service definition (Specify):

r. ____ Adult Residential Care (Check all that apply):

____ Adult foster care: Personal care and services, homemaker, chore, attendant care and companion services, medication oversight (to the extent permitted under State law) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult foster care is furnished to adults who receive these services in conjunction with residing in the home. The total number of individuals (including persons served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed six. Separate payment will not be made for homemaker or chore services furnished to an individual receiving adult foster care services, since these services are integral to and inherent in the provision of adult foster care services.

____ Assisted living: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The beneficiary has a right to privacy. Living units may be locked at the discretion of the beneficiary, except when a physician or mental health professional has certified in writing that the beneficiary is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The beneficiary retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way that fosters the independence of each beneficiary to facilitate aging in place. Routines of care provision and service delivery must be beneficiary-driven to the maximum extent possible, and treat each person with dignity and respect.

Assisted living services may also include (Check all that apply):

____ Home health care

____ Physical therapy

- ___ Occupational therapy
- ___ Speech therapy
- ___ Medication administration
- ___ Intermittent skilled nursing services
- ___ Transportation specified in the plan of care
- ___ Periodic nursing evaluations
- ___ Other (Specify)

However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. FFP is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility.

Payments for adult residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep, and improvement. Payment for adult residential care services does not include payments made, directly or indirectly, to members of the consumer's immediate family. The methodology by which payments are calculated and made is described in Appendix G.

s. ___ Extended State Plan services:

The following services, available through the approved State Plan, will be provided, except that the limitations on amount, duration, and scope specified in the plan will not apply. Services will be as defined and described in the approved State Plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State Plan until the plan limitations have been reached. Documentation of the extent of service(s) and cost-effectiveness are demonstrated in Appendix G. (Check all that apply):

- ___ Physician services
- ___ Home health care services
- ___ Physical therapy services
- ___ Occupational therapy services
- ___ Speech, hearing and language services
- ___ Prescribed drugs
- ___ Other State Plan services (Specify):

t. X Other waiver services which are cost-effective and necessary to prevent institutionalization (Specify):

1. Utility Coverage: Electric services necessary to prevent reinstitutionalization for waiver beneficiaries at the nursing facility Level A or Level B level of service, who are dependent upon medical technology. Utility coverage must be included in the POT and the MOHS. Prior authorization must be obtained by the waiver service provider from the designated Medi-Cal office for this service.

There is a minimum monthly amount of \$20.00 that must be reached before this service will be authorized. When the minimum amount has been reached, the waiver will reimburse the beneficiary all charges up to a monthly maximum amount of \$75.00.

Utility coverage is limited to that portion of the utility bills directly attributable to operation of life sustaining medical equipment in the beneficiary's place of residence. For purposes of this waiver service, "life sustaining medical equipment" is defined as: mechanical ventilation equipment and other respiratory therapy equipment, suction machines, cardiorespiratory monitors, feeding pumps, and infusion equipment. Notwithstanding this definition, in the event a specific medical need is identified in the POT, a consultation between the IHO Nurse Case Manager and the IHO program consultants (medical or nursing) will evaluate requests for and may grant exceptions to this definition.

Utility coverage is provided through the local utility company. The waiver service provider will submit a request for the authorization of this service. Upon receipt of payment for any claim for this service, the waiver service provider will then give the monies to the beneficiary.

In order to calculate the cost per unit of time, the authorization for waiver utility services includes consideration of the type of equipment and frequency of use. Cost factors to operate electrical equipment are supplied by utility companies and are based on a consideration of the equipment's size, voltage requirement and amperage requirement. Upon identifying the power requirements of the equipment and the utility rates per kilowatt-hour, a utility company can estimate the cost of operation of the equipment to within a few cents per unit of time.

The waiver service provider is responsible for assuring notification to utility providers that services are being provided to an individual dependent upon life sustaining medical equipment. Documentation indicating this notification has been made and, as appropriate, revised shall be kept in the beneficiary's medical record in the provider's files.

2. Waiver Service Coordination: Coordination of needs for individuals who have complex medical services with multiple funding sources through public or private entities for needed services to be maintained in home or community based settings. These multiple funding sources could include Medi-Cal related services, California

Children's Services for individuals under the age of 21, Regional Center, Department of Rehabilitation, county funded services, Medicare, private insurance.

This service will include educating the beneficiary and/or caregivers about the different funding sources and helping to assist the beneficiary and/or caregivers in understanding the various services he/she is receiving or may receive and the impact, if any, of the services received/requested, based on the source of funding. Waiver Service Coordination will supplement the case management activities authorized under this waiver or through other entities including the state plan benefit of targeted case management. Waiver Service Coordination activities will not involve the authorization of services, care planning or locating needed services.

The requested service with supporting documentation submitted to substantiate the medical necessity for the requested service, as well as credentials for providing these requested services, will be thoroughly reviewed by MCO staff assigned to the case.

a. Services provided by family members:

Waiver Service Coordination providers may be members of the individual's family. Payment will not be made for services furnished by the person legally responsible for the individual. This would include parental responsibilities for a minor or spouse of the individual.

b. Justification:

Individuals who provide Waiver Service Coordination services must meet the standards as indicated in subsection a. page B-1.

Criteria for service provider(s) will include written documentation of experience in coordinating such services and how they will coordinate the waiver services with other services received by the beneficiary. This documentation will be included on the plan of treatment and updated as needed. Must include service coordination beyond the use of Medi-Cal linked services and Regional Center services.

u. ____ Services for individuals with chronic mental illness consisting of (Check one):

____ Day treatment or other partial hospitalization services (Check one):

____ Services that are necessary for the diagnosis or treatment of the individual's mental illness. These services consist of the following elements:

- a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),

- b. occupational therapy, requiring the skills of a qualified occupational therapist,
- c. services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness,
- d. drugs and biologicals furnished for therapeutic purposes,
- e. individual activity therapies that are not primarily recreational or diversionary,
- f. family counseling (the primary purpose of which is treatment of the individual's condition),
- g. training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and
- h. diagnostic services.

Meals and transportation are excluded from reimbursement under this service. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

_____ Other service definition (Specify):

_____ Psychosocial rehabilitation services (Check one):

_____ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

- a. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);
- b. social skills training in appropriate use of community services;
- c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and
- d. telephone monitoring and counseling services.

The following are specifically excluded from Medicaid payment for psychosocial rehabilitation services:

- a. vocational services,
- b. prevocational services,
- c. supported employment services, and
- d. room and board.

____ Other service definition (Specify):

____ Clinic services (whether or not furnished in a facility) are services defined in 42 CFR 440.90.

Check one:

____ This service is furnished only on the premises of a clinic.

____ Clinic services provided under this waiver may be furnished outside the clinic facility. Services may be furnished in the following locations (Specify):

Appendix B-2, Provider Qualifications**A. LICENSING AND CERTIFICATION CHART**

The following chart indicates the requirements for the provision of each service under the waiver. Licensing, Regulation, Statute, and California Code of Regulations are referenced by citation. Standards not addressed under uniform State citation are attached.

Service	Provider Type	Practitioner	License	Certification	Other Standard
Case Management	HHA	Registered Nurse (RN)	CCR, Title 22, §§74659 – 74689 CCR, Title 22, §51067; BPC, §§ 2725-27 42		
Case Management	Private duty nursing agency (PDNA)	RN, LVN	RN: CCR, Title 22, §51067; BPC, §§ 2725-2742		Health & Safety Code, § 1743 and W & IC §14105.13
Case Management	Individual Nurse Provider	RN	CCR, Title 22, §51067; BPC: §§ 2725-2742		
Case Management	Individual Licensed Professional	MFCC, Clinical Psychologist, LCSW or equivalent qualifications	BPC: §§ 4980 (b); §2902; § 4996		CCR, Title 22, § 51147, MSW from Accredited School of Social Work
Case Management	Professional Organization	MFCC, Clinical Psychologist, LCSW or equivalent qualifications	BPC: § 4980 (b); §2902; § 4996		CCR, Title 22, § 51147, MSW from Accredited School of Social Work
Personal Care Services	HHA	CHHA	CCR, Title 22, §§74659 – 74689	CHHA: CCR, Title 22, §74624	CCR, Title 22, §51181, §51183, §51204, §51350 and W &IC §12302
Personal Care Services	Individual Personal Care Provider	Unlicensed individual			CCR, Title 22, §51181, §51183, §51204, §51350 and W &IC §12302
Personal Care Services	Professional Organization	Unlicensed individual	Business License as appropriate		

Service	Provider Type	Practitioner	License	Certification	Other Standard
Respite	Individual Nurse Provider	RN, Licensed Vocational Nurse (LVN)	CCR, Title 22, §§51067; BPC, §§ 2725-2742 LVN: CCR, Title 22, §§51069; BPC, §§ 2859-2873.7		
Respite	HHA	RN, LVN, Certified Home Health Aide (CHHA)	HHA: CCR, Title 22, §§74659 – 74689 RN: CCR, Title 22, §§51067; BPC, §§ 2725-2742 LVN: CCR, Title 22, §§51069; BPC, §§ 2859-2873.7		
Respite	PDNA	RN, LVN	RN: CCR, Title 22, §§51067; BPC, §§ 2725-2742 LVN: CCR, Title 22, §§51069; BPC, §§ 2859-2873.7		Health & Safety Code, § 1743 and W & IC §14105.13
Respite	Individual Personal Care Provider	Unlicensed individual			CCR, Title 22, §51181, §51183, §51204, §51350 and W & IC §12302
Respite	Nursing Facilities providing NF A/B services	RN, LVN, Certified Nurse Aid (CNA)	CCR, Title 22, §§51118, 51120, 51120.5, 51121		CCR, Title 22, §72103
Environmental Accessibility Adaptations	DME Provider, Building Contractor, Private nonprofit or proprietary agency; As appropriate for services to be purchased		Contractor License, Business License		
Personal Emergency Response Systems	DME Provider, Private nonprofit or proprietary agency. As appropriate for services to be purchased		Business license, as appropriate		

Service	Provider Type	Practitioner	License	Certification	Other Standard
Private Duty Nursing – Individual Care or Shared Nursing Care	Individual Nurse Provider	RN, LVN	RN: CCR, Title 22, §§51067; BPC, §§ 2725-2742 LVN: CCR, Title 22, §§51069; BPC, §§ 2859-2873.7		
Private Duty Nursing – Individual Care or Shared Nursing Care	HHA	RN, LVN, CHHA	RN: CCR, Title 22, §§51067; BPC, §§ 2725-2742 LVN: CCR, Title 22, §§51069; BPC, §§ 2859-2873.7 HHA: CCR, Title 22, §§74659 – 74689	CHHA: CCR, Title 22, §74624	
Private Duty Nursing – Individual Care or Shared Nursing Care	PDNA	RN, LVN	RN: CCR, Title 22, §§51067; BPC, §§ 2725-2742 LVN: CCR, Title 22, §§51069; BPC, §§ 2859-2873.7		Health & Safety Code, § 1743 and W & IC §14105.13
Private Duty Nursing – Individual Care or Shared Nursing Care	CLHF-Type A	RN, LVN, CNA	RN: CCR, Title 22, §§51067; BPC, §§ 2725-2742 LVN: CCR, Title 22, §§51069; BPC, §§ 2859-2873.7	CCR, Title 22, §51173.1H&S Code §1250(i)(1)	CCR, Title 22, §51181, §51183, §51204, §51350 and W&IC §12302
Family Training	HHA	RN	HHA: CCR, Title 22, §§74659 – 74689 RN: CCR, Title 22, §51067; BPC, §§ 2725-2742		
Family Training	PDNA	RN	RN: CCR, Title 22, §51067; BPC, §§ 2725-2742		Health & Safety Code, § 1743 and W & IC §14105.13
Family Training	Individual Nurse Provider	RN	RN: CCR, Title 22, §51067; BPC, §§ 2725-2742		

Service	Provider Type	Practitioner	License	Certification	Other Standard
Other Services					
Waiver Service Coordination	HHA/PDNA, Individual Nurse Provider, Individual Licensed Professional, Professional Organization	RN, MFCC, Clinical Psychologist, LCSW or similar qualifications	CCR, Title 22, §§ 74659 – 74689; CCR Title 22, §51067; BPC, §§2725-2742; §2902; §4980(b); §4996		CCR, Title 22, § 51147, MSW from Accredited School of Social Work
Utility Coverage	HHA/PDNA, Individual Nurse Provider, Individual Licensed Professional, Professional Organization	HHA/PDNA, Individual Nurse Provider, Individual, Licensed Professional, Professional Organization	Public Utilities Commission		Services arranged by agreement CCR, Title 22, §74719 with HHA/PDNA; Individual Nurse Provider; Individual Licensed Professional, Professional Organization or assigned by MCOD

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification *and/or training* requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

Appendix B-3, Keys Amendment Standards for Board and Care Facilities**KEYS AMENDMENT ASSURANCE:**

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

- ☐ Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.
- ☒ A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

Appendix B-4, Individual Nurse Providers**Criteria For Service Authorization****HCBS Waivers****A. DEFINITIONS:**

“Individual nurse provider” means a Registered Nurse or a Licensed Vocational Nurse, who provides individual nurse provider services, as defined in subsection A.2, below, and, in this capacity, is not employed by or otherwise affiliated with a home health agency or any other licensed health care provider, agency, or organization. An individual nurse provider shall not be a parent, stepparent, foster parent, spouse, or legal guardian of the patient.

1. “Individual nurse provider services” means private duty nursing services, as defined in subsection A.3, below, provided to a beneficiary in his/her home or place of residence by an individual nurse provider, as defined in subsection A.1, above, within his/her scope of practice. Such services shall not include nursing services provided in a licensed health facility.
2. “Private duty nursing services” means services provided by a Registered Nurse or a Licensed Vocational Nurse, which are more individual and continuous than those routinely available through a home health agency as in part-time or intermittent care on a limited basis.
3. “Medi-Cal Consultant” means either a Registered Nurse or Physician, who is licensed to practice in the State and is an employee of MCOI-IHO.
4. “Education and/or training requirements” means any type of formal instruction related to the care needs of the individual for whom services are being requested. Examples of this could include certifications in a particular field, appropriate to the licensure status of the nurse; or continuing education units in the needs of the beneficiary such as wound or pain management.
5. “Evaluation of theoretical knowledge and manual skills” means an assessment conducted by the registered nurse (RN) or the licensed vocational nurse (LVN) in which the LVN is able to demonstrate competency in the provision of skilled nursing services. Examples of this could include having the LVN verbalize requirements for a certain procedure/process; having the RN review a certain task, demonstrate the task and then observing the LVN perform the tasks as prescribed on the plan of treatment. This evaluation would need to be documented and provided to MCOI-IHO as indicated.

B. REQUIREMENTS OF THE INDIVIDUAL NURSE PROVIDER:

1. Registered Nurse (RN) acting as the direct care provider:
 - a. The initial Treatment Authorization Request (TAR) shall be accompanied by all of the following documentation:

- (i) Current license to practice as an RN in the State of California.
- (ii) Current Basic Life Support (BLS) certification.
- (iii) Written evidence, in a format acceptable to the Department, of training or experience, which shall include at least one of the following:
 - A. A minimum of 1000 hours of experience in the previous two years, in an acute care hospital caring for patients with the care need(s) specified on the TAR and plan of treatment. At least 500 of the 1000 hours shall be in a hospital intensive care unit.
 - B. A minimum of 2000 hours of experience in the previous three years, in an acute care hospital caring for patients with the care need(s) specified on the TAR and plan of treatment.
 - C. A minimum of 2000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) specified on the TAR and plan of treatment.
- (iv) Detailed plan of treatment that reflects appropriate nursing assessment of the beneficiary, appropriate interventions, and the physician's orders.
 - A. The appropriateness of the nursing assessment and interventions shall be determined by the Medi-Cal consultant based upon the beneficiary's medical condition and care need(s).
 - B. The plan of treatment shall be signed by the beneficiary, the RN and the beneficiary's physician, and shall contain the dates of service.
- (v) Signed release form from the beneficiary's physician, which shall specify both of the following:
 - A. The physician has knowledge that the RN providing care to the beneficiary is doing so without the affiliation of a home health agency or other licensed health care agency of record.
 - B. The physician is willing to accept responsibility for the care rendered to the beneficiary.
- (vi) Written home safety evaluation, in a format acceptable to the Department that demonstrates that the beneficiary's home environment supports the health and safety of the individual. This documentation shall include all of the following:
 - A. The area where the beneficiary will be cared for will accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies necessary to maintain the individual in the home in comfort and safety, and to facilitate the nursing care required.

- B. Primary and back-up utility, communication, and fire safety systems and devices are installed and available in working order, which shall include grounded electrical outlets, smoke detectors, fire extinguisher, telephone, and notification of utility, emergency, and rescue systems that a person with special needs resides in the home.
 - C. The home is in compliance with local fire, safety, building and zoning ordinances, and the number of persons residing in the home does not exceed that permitted by such ordinances.
 - D. All medical equipment, supplies, primary and back-up systems, and other services and supports, identified in the plan of treatment, are in place and available in working order, or have been ordered and will be in place at the time the beneficiary is placed in the home.
- (vii) History and physical completed by the beneficiary's physician within the previous three months for an individual under the age of 21 and within the previous six months for an individual 21 years of age or older. If the last history and physical was completed outside of the respective timeframes, the history and physical shall be accompanied by documentation of the most recent office visit which shall contain a detailed summary of medical findings that includes a body systems examination.
- b. All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:
 - (i) Evidence of renewal of BLS certification and RN licensure prior to expiration.
 - (ii) Written evidence, in a format acceptable to the Department, of on-going education or training caring for the type of individual for whom services are being requested, at least once per calendar year.
 - (iii) Written evidence, in a format acceptable to the Department, of on-going contact with the beneficiary's physician for the purpose of informing the physician of the individual's progress, updating or revising of the plan of treatment, and renewal of physician orders.
 - (iv) Updated plan of treatment that reflects ongoing nursing assessment and interventions, and updated physician orders. The updated plan of treatment shall be signed by the beneficiary's physician, the RN, the beneficiary and will contain the dates of service.
2. RN supervisor acting as the supervisor for an individual nurse provider who is a Licensed Vocational Nurse (LVN):
- a. The initial TAR shall be accompanied by all of the following documentation:
 - (i) Current license to practice as an RN in the State of California.

- (ii) Current BLS certification.
 - (iii) Written evidence, in a format acceptable to the Department, of training or experience, as specified in section B, subsection 1.a. (iii) “requirements of the individual nurse provider”, above.
 - (iv) Written evidence, in a format acceptable to the Department, of training or experience providing supervision or delegating nursing care tasks to an LVN or other subordinate staff.
 - (v) Detailed plan of treatment, as specified in section B, subsection 1.a. (iv) “requirements of the individual nurse provider”, above.
 - (vi) Written summary, in a format acceptable to the Department, of nursing care tasks that have been delegated to the LVN.
- b. All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:
- (i) Evidence of renewal of BLS certification and RN licensing prior to expiration.
 - (ii) Written summary, in a format acceptable to the Department, of all supervisory activities which shall include all of the following:
 - A. Evaluation of the LVN’s theoretical knowledge and manual skills needed to care for the individual for whom services have been requested.
 - B. The training provided to the LVN, as needed, to ensure appropriate care to the beneficiary for whom services have been requested.
 - C. Monitoring of the care rendered by the LVN, which shall include validation of post-training performance.
 - D. Any change in the nursing care tasks delegated to the LVN.
 - (iii) Written evidence of ongoing contact with the beneficiary’s physician, as specified in section B., subsection 1.b. (iii), “requirements of the individual nurse provider”, above.
 - (iv) Updated plan of treatment, as specified in section B, subsection 1.b. (iv), “requirements of the individual nurse provider”, above.
3. LVN acting as the direct care provider:
- a. The initial TAR shall be accompanied by all of the following documentation:
 - (i) Current license to practice as an LVN in the State of California.
 - (ii) Current BLS certification.

- (iii) Name and RN license number of the individual who will be providing ongoing supervision. Such supervision shall be required at a minimum of two hours per calendar month.
 - (iv) Written evidence, in a format acceptable to the Department, of training or experience, as specified in section B, subsection 1.a. (iii), “requirements of the individual nurse provider”, above.
 - (v) Copy of the detailed plan of treatment that reflects the RN nursing assessment of the beneficiary and the physician’s orders. The plan of treatment shall be signed by the supervising RN, the beneficiary’s physician, the beneficiary, and the LVN.
 - (vi) Written home safety evaluation, in a format acceptable to the Department, as specified in section B, subsection 1.a. (vi), “requirements of the individual nurse provider”, above.
 - (vii) History and physical, as specified in section B., subsection 1.a. (vii), “requirements of the individual nurse provider”, above.
- b. All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:
- (i) Evidence of renewal of BLS certification and LVN licensure prior to expiration.
 - (ii) Written evidence, in a format acceptable to the Department, of on-going education or training caring for the type of individual for whom services are being requested, at least once per calendar year.
 - (iii) Copy of the updated plan of treatment that reflects ongoing RN nursing assessment and updated physician orders. The plan of treatment shall be signed by the supervising RN, the beneficiary’s physician, the beneficiary, and the LVN, and shall contain the dates of service.
4. A TAR, or similar request must be approved in advance by MCOD-IHO and shall be required for each individual nurse provider service request. Initial authorization shall be granted for a period of up to 90 days, and reauthorization shall be granted for periods of up to 180 days.
5. The individual nurse provider shall agree to notify MCOD-IHO and the beneficiary or his/her legal guardian, in writing, at least thirty (30) days prior to the effective date of termination when the individual nurse provider intends to terminate individual nurse provider services. This time period may be less than thirty (30) days if there are immediate issues of health and safety for either the nurse or the beneficiary, as determined by the MCOD-IHO.

APPENDIX C, ELIGIBILITY AND POST-ELIGIBILITY**Appendix C-1, Eligibility****Medicaid Eligibility Groups Served**

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. **(Check all that apply.)**

1. ☒ Low income families with children as described in Section 1931 of the Social Security Act.
2. ☒ SSI recipients (SSI Rules States and 1634 States).
3. ☐ Aged, blind or disabled in 209(b) States who are eligible under § 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).
4. ☒ Optional State supplement recipients
5. ☐ Optional categorically needy aged and disabled who have income at (Check one):
 - a. ☐ 100% of the Federal poverty level (FPL)
 - b. ☐ % Percent of FPL which is lower than 100%.
6. ☒ The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

☒ A. Yes ☐ B. No

Check one:

- a. ☒ The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community. The enrollment of beneficiaries for HCBS services under this method of determining eligibility will be capped for each fiscal year (see Assumptions in Appendix G);or
- b. ☐ Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1) ___ A special income level equal to:

___ 300% of the SSI Federal benefit (FBR) ___% of FBR, which is lower than 300% (42 CFR 435.236) \$ ___ which is lower than 300%

(2) ___ Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3) ___ Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435.324)

(4) ___ Medically needy without spenddown in 209(b) States. (42 CFR 435.330)

(5) ___ Aged and disabled who have income at:

a. ___ 100% of the FPL

b. ___% which is lower than 100%.

(6) ___ All other mandatory and optional groups under the plan are included.

7. X Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8. X All other mandatory and optional groups under the plan are included.

9. ___ Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

Appendix C-2, Post-Eligibility**General Instructions**

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under §435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community (§435.217). For individuals whose eligibility is not determined under the spousal rules (§1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR §435.726 and §435.735 just as it does for other individuals found eligible under §435.217 or;

OPTION 2: It may use the spousal post-eligibility rules under §1924.

Regular Post-Eligibility Rules--§435.726 and §435.735

- The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.
- If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.
- If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.
- If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a family of the same size

or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

Spousal Post-Eligibility--§1924

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of §1924 of the Act (protection against spousal impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The §1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in §1902(q)(1)" for the needs of the institutionalized individual. This is an allowance "which is reasonable in amount for clothing and other personal needs of the individual . . . while in an institution." For institutionalized individuals this amount could be as low as \$30 per month, but must be a reasonable amount for clothing and other personal needs of an individual while in an institution. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. Therefore, the \$30 PNA may not be a reasonable amount when the waiver recipient is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the §1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community.

Appendix C-3, Waiver of Community Income and Resource Policies for the Medically Needy

(§§ 1915 (c) (3) and 1902 (a) (10) (C) (i) (III) of the Social Security Act).

- A. A waiver of §1902 (a) (10) (C) (i) (III) of the Social Security Act is requested for the medically needy, only as reflected in section C., below.
- B. Computation of income for purposes of FFP limits is not applicable (N/A).
- C. The following is a description of the income and resource methods and standards that differ from those otherwise required for the medically needy under the State plan (including approved §1902 (r) (2) policies) and §1902 (a) (10) (C) (i) (III) for individuals living in the community.

Second Vehicle Exemption for Waiver Program: A recipient may claim an exemption for a second, modified vehicle if it was modified to accommodate the physical handicap(s) or the medical needs of the individual. Verification shall be by physician's written statement of necessity.

Post Eligibility**Regular Post Eligibility**

1. X **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipient's income.

A. § 435.726--States which **do not use more restrictive** eligibility requirements than SSI.

a. Allowances for the needs of the

1. individual: (Check one):

A. ___ The following standard included under the State plan (check one):

(1) ___ SSI

(2) ___ Medically needy

(3) ___ The special income level for the institutionalized

(4) ___ The following percent of the Federal poverty level): ___%

(5) X Other (specify):

An amount which represent the sum of (1) the income standard used to determine eligibility/share of cost and (2) any amounts of income disregarded during the Section 1902(a)(10)(A)(ii)(VI) eligibility phase.

B. ___ The following dollar amount: \$ ___*

* If this amount changes, this item will be revised.

C. ___ The following formula is used to determine the needs allowance:

Note: If the amount protected for waiver recipients in item 1, is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2 and 3**, following.

2. spouse only (check one):

A. ___ SSI standard

B. ___ Optional State supplement standard

C. ___ Medically needy income standard

D. ____ The following dollar amount: \$ ____ *

*If this amount changes, this item will be revised.

E. ____ The following percentage of the following standard that is not greater than the standards above: ____ % of ____ standard.

F. ____ The amount is determined using the following formula:

G. X Not applicable (N/A)

3. Family (check one):

A. ____ AFDC need standard

B. ____ Medically needy income standard ____;

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C. ____ The following dollar amount: \$ ____ *

*If this amount changes, this item will be revised.

D. ____ The following percentage of the following standard that is not greater than the standards above: % ____ of ____ standard.

E. ____ The amount is determined using the following formula:

F. ____ Other

G. X Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

Post-Eligibility**Regular Post Eligibility****1.(b)___209(b) State. A State that is using more restrictive eligibility requirements than SSI.**

The State is using the post-eligibility rules at 42 CFR 435.735. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipient's income.

B. 42 CFR 435.735--States using more restrictive requirements than SSI.**a. Allowances for the needs of the****1. individual: (check one):****A. ___ The following standard included under the State plan (check one):****(1)___ SSI****(2)___ Medically needy****(3)___ The special income level for the institutionalized****(4)___ The following percentage of the Federal poverty level: ___ %****(5)___ Other (specify):****B. ___ The following dollar amount: \$ ___ ****** If this amount changes, this item will be revised.****C. ___ The following formula is used to determine the amount:**

Note: If the amount protected for waiver recipients in 1, is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under §435.217, **enter NA in items 2 and 3** following.

2. spouse only (check one):**A. ___ The following standard under 42 CFR 435.121:****B. ___ The medically needy income standard ___;****C. ___ The following dollar amount: \$ ___ ******If this amount changes, this item will be revised.****D. ___ The following percentage of the following standard that is not greater than the standards above: ___ % of _____.**

E.____ The following formula is used to determine the amount:

3. family (check one):

A.____ AFDC need standard

B.____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.____ The following dollar amount: \$____*

*If this amount changes, this item will be revised.

D.____ The following percentage of the following standard that is not greater than the standards above: ____% of ____ standard.

E.____ The following formula is used to determine the amount:

F. Other

G. Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.735.

Post Eligibility**Spousal Post Eligibility**

2. X The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution towards the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

A. Allowance for personal needs of the individual: (check one)

1) Institutional PNA: Specify the amount: \$

*Explain why you believe this amount is reasonable to meet the maintenance needs of the individual in the community.

2) An amount which is comparable to the amount used as the maintenance allowance of the individual for home and community based waiver recipients who have no community spouses. (check one):

(a) SSI Standard

(b) Medically Needy Standard

(c) The special income level for the institutionalized

(d) The following percent of the Federal poverty level: %

(e) X Other (specify):

An amount which represents the sum of (1) the income standard used to determine eligibility/share of cost and (2) any amounts of income disregarded during the Section 1902(a)(10)(A)(ii)(VI) eligibility phase,

(f) The following dollar amount: \$ **

**If this amount changes, this item will be revised.

(g) The following formula is used to determine the needs allowance:

APPENDIX D, ENTRANCE PROCEDURES AND REQUIREMENTS**Appendix D-1, Evaluation of Level of Care****a. Evaluation of Level of Care**

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

B. Qualifications of Individuals Performing Initial Evaluation

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (Check all that apply):

_____ Discharge planning team

_____ Physician (M.D. or D.O)

 X Registered Nurse, licensed in the State and who is an employee of DHS-MCOD.

_____ Licensed Social Worker

_____ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

 X Other (Specify): Physician (M.D. or D.O.) licensed in the State and who is an employee of DHS-MCOD.

c. Criteria For Denial of Initial Request For Services

The initial request for Nursing Facility Level A or Level B Waiver services shall be denied when:

- (1) The enrollment cap for the waiver has been met for the current fiscal year (the individual will be placed on a wait list if they so choose)
- (2) The request does not meet NF A/B LOC described in this waiver
- (3) The cost of the requested services exceeds the institutional cost of NF A/B level of care and the beneficiary **does not** agree to a reduction in the requested services. Any reduction in requested services must still provide a program that assists in meeting the beneficiary's health and safety needs

- (4) There is not an identified support network system available to the beneficiary and attempts have been made by the HCBS waiver service provider and /or MCO-IHO to assist in the development/maintenance of this system without success.
- (4) The beneficiary is not able to establish Medi-Cal eligibility
- (5) The request for services does not meet medical eligibility criteria used to determine NF A/B service eligibility as outlined in Title 22, CCR, Sections 51120, 51124, 51334 and 51335.
- (6) The beneficiary or the authorized representative, to the extent the beneficiary needs support, elects in writing to withdraw the request for services.
- (7) The provider of NF A/B Waiver services for the beneficiary is unwilling or unable to assure that the beneficiary is receiving either the quantity or quality of NF A/B Waiver services required by the beneficiary's POT and physician orders. In such case, the Department will assist the beneficiary with either finding appropriate waiver providers or with the authorization process for the beneficiary at the otherwise appropriate level of institutional care.
- (8) The beneficiary's condition is not stable, as demonstrated by repeated unplanned hospitalizations.
- (9) The beneficiary or the beneficiary's authorized representative declines the case management services when they elect to receive "Waiver Personal Care Services" as their sole waiver service.
- (10) The beneficiary's condition changes such that he/she needs a level of service different from that identified in the previous NF A/B Waiver POT or LOC documentation.
- (11) The beneficiary becomes deceased.

When NF A/B Waiver services are denied, reduced or terminated by the Department, a Notice of Action will be forwarded to the beneficiary in conformance with 42 CFR Part 431, Subpart E.

Appendix D-2, Reevaluations of Level of Care

a. Reevaluations of Level of Care

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (Specify):

___ Every 3 months

X Every 6 months by DHS-MCOD staff. The re-evaluations for the level of care will be completed by conducting the visits to the beneficiary's place of residence.

___ Every 12 months

___ Other (Specify):

b. Qualifications of Persons Performing Reevaluations

Check one:

X The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

___ The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (Specify):

___ Physician (M.D. or D.O.)

___ Registered Nurse, licensed in the State

___ Licensed Social Worker

___ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

___ Other (Specify):

c. Procedures to Ensure Timely Reevaluations

The State will employ the following procedures to ensure timely reevaluations of level of care (Check all that apply):

___ "Tickler" file

___ Edits in computer system

X Component part of case management (*conducted by DHS-MCOD staff*)

X Other (Specify): DHS-MCOD Database Query for next schedule home visit

d. Criteria For Modification or Termination of Nursing Facility Level A And Level B Waiver Services

Requests for reauthorization of Nursing Facility Level A or B (NF A/B) Waiver services shall be **modified** when any one of the following circumstances occur:

- (1) The cost of the requested services exceeds the cost of the institutional NF A/B level of care and the beneficiary or, if appropriate, the authorized representative **does not agree** to a reduction in the requested services. The approved services must be cost neutral and must provide a program that assists in meeting the beneficiary's health and safety needs
- (2) The beneficiary loses Medi-Cal eligibility
- (3) The beneficiary or, if appropriate, the authorized representative to the extent the beneficiary needs support, or the identified provider of services gives a 30 day notice of termination and there are qualified providers of service who have not agreed to provide the requested services for the beneficiary. The DHS-MCOD nurse case manager will assist the beneficiary or the authorized representative in identifying any alternatives that may help meet the medical care needs of the waiver recipient.
- (4) The DHS-MCOD nurse case manager or other appropriate program staff, in consultation with the beneficiary's primary physician, agrees that the beneficiary's condition has changed to the point that he/she no longer meets the medical eligibility criteria used to determine NF A/B Waiver services eligibility.

NF A/B Waiver services shall be **terminated or shall not be reauthorized** by the Department when any one of the following circumstances occur:

- (1) The Department determines that circumstances pose an immediate threat to the health and safety of the beneficiary:
- (2) The cost of the requested services exceeds the cost of the institutional NF A/B level of care and the beneficiary **does not agree** to a reduction in the requested services. To be appropriate, the approved waiver services must be cost neutral and must provide for a plan that assists in meeting the beneficiary's health and safety needs.
- (3) The beneficiary receiving NF A/B Waiver services refuses to comply with the primary care physician's orders or POT.
- (4) The identified support network system available to the beneficiary is no longer in place and attempts have been made by the HCBS waiver service provider and /or MCOD-IHO to assist in the development/maintenance of this system without success.
- (5) The spouse, parent, designated family member, licensed foster parent, or other responsible individual cannot be identified or is no longer willing or available to

assume the responsibility to act as back-up caregiver for the care needs of the beneficiary.

- (6) The spouse, parent, designated family member, licensed foster parent, or other responsible individual caregiver refuses to comply with the attending physician's orders or POT.
- (7) The home/family assessment fails to demonstrate an environment that supports the beneficiary's health and safety, or otherwise is not conducive to the provision of waiver services. Home safety will be determined by a home safety evaluation submitted by the primary provider of services. Additionally, when prescribed home visits are made, home safety will be addressed and documented in the "Home Safety Evaluation" section on the "Case Management Report" (Attachment to Appendix D-2) used by DHS-MCOD staff. Prior to denying or terminating services, a plan of correction will be put in place by the provider. The DHS-MCOD staff will then follow-up to determine if the plan has been effective and what further actions, if any, implemented.
- (8) The provider of NF A/B Waiver services for the beneficiary is unwilling or unable to assure that the beneficiary is receiving either the quantity or quality of NF A/B Waiver services required by the beneficiary's POT and physician orders. In such case, the Department will assist the beneficiary with either finding appropriate waiver providers or with the authorization process for the beneficiary at the otherwise appropriate level of institutional care.
- (9) The beneficiary's condition is not stable, as demonstrated by repeated unplanned hospitalizations.
- (10) The beneficiary or the beneficiary's authorized representative declines the case management services when they elect to receive "Waiver Personal Care Services" as their sole waiver service.
- (11) The beneficiary's condition changes such that he/she needs a level of service different from that identified in the previous NF A/B Waiver POT or LOC documentation.
- (12) The beneficiary or his/her authorized representative elects in writing to terminate NF A/B Waiver Services.
- (13) The beneficiary becomes deceased.

When NF A/B Waiver services are denied, reduced or terminated by the Department, a Notice of Action will be forwarded to the beneficiary in conformance with 42 CFR Part 431, Subpart E.

Appendix D-3, Maintenance of Records

a. Maintenance of Records

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (Check all that apply):

☐ By the Medicaid agency in its central office

☐ By the Medicaid agency in district/local offices

☒ By the agency designated in Appendix A as having primary authority for the daily operations of the waiver program

☒ By the case managers *employed by DHS-MCOD*

☒ By the persons or agencies designated as responsible for the performance of evaluations and reevaluations

☐ By service providers

☐ Other (Specify):

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

b. Copies of Forms and Criteria for Evaluation/Assessment

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix.

The criteria used for waiver level of care is determined by criteria established in Title 22, CCR, Division 3, Sections 51120, 51124, 51334, 51335 and information submitted on the Treatment Authorization Requests which support medical necessity for the services as defined in Title 22, CCR, Section 51003. This information is used for initial and ongoing reevaluations of all services authorized under the auspices of the NF A/B waiver.

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

☒ The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.

— The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

c. Criteria by Which the Level of Service Decision is Made

The NF A/B Waiver target population consists of Medi-Cal eligible disabled persons whom the attending primary care physician and the Medi-Cal consultant agree would, as a practical matter, in the absence of the waiver, be expected to require at least 365 consecutive days of the level of service provided in a nursing facility at the A or B level of care.

- (1) The Medi-Cal consultant shall be a physician or a Registered Nurse.
- (2) The population targeted for this waiver includes beneficiaries for whom inpatient nursing facility care is currently authorized at the NF A or B level and is expected to be authorized for at least 365 consecutive days, and beneficiaries who are in the community but who, in the absence of the waiver, are likely to require institutionalization in a nursing facility at the NF A or B level of care for at least 365 consecutive days.
- (3) A determination of medical eligibility for this waiver shall be based upon all of the following requirements:
 - (a) Completed appropriate NF A/B Waiver services assessment. A NF A/B Waiver services assessment means an assessment, conducted by the Department. The initial assessment is documented on the Intake Medical Summary form (copy attached). The NF A/B Waiver services assessment enables the Department to determine, among other things, the following:
 - i. Identification of an attending physician who provides beneficiary-specific written orders;
 - ii. A complete and accurate written medical record exists, including diagnoses, history and physical assessment, treatment plan and prognosis;
 - iii. A medical need exists for the level of services requested; and
 - iv. A determination that the services to be provided will maintain program cost neutrality.
- (4) To transition waiver recipients at the NF A and NF B level of care from the current NF waiver #0139.90.R1 into the new Nursing Facility NF A/B Waiver, the State will evaluate each recipient using the criteria that has been developed for this waiver as indicated in item 4, subsection d of this waiver request. Continued Medi-Cal eligibility shall also be ascertained for the individual recipient. If it is determined that a recipient receiving services under the current NF waiver is ineligible for transition to the new NF A/B Waiver, the individual will be evaluated for a determination of appropriateness for transition to either the In-Home Medical Care Services (IHMC) Waiver or the NF

Subacute (NF SA) Waiver. Any transition is conditioned on determination that an individual meets the specific criteria described in the respective waivers.

Attachment To Appendix D-3

- **Intake Medical Summary (Form And Instructions)**
- **Case Management Summary (Form And Instructions)**
- **Home Safety Evaluation (Form And Instructions)**
- **Menu of Home and Community-Based Services**

Waiver Services (MOHS) Form

- **Instructions For MOHS Form:**

IHO Nurse Case Manager to input the number of units of requested/ authorized services using drop down menus within the spreadsheet. Document is set-up to automatically calculate the totals in the appropriate columns.

**In-Home Operations –
INTAKE MEDICAL SUMMARY (IMS):**

IHO Region:

☐

North

☐

South

Name:

Date of Visit:

SSN:

Case Manager:

Directions to Home**Home Visit Summary**

Purpose of Visit:

Persons Present:

Living Arrangements:

Chart and POT Review:

Staffing Issues:

Medical History:

Review of Home Safety
(please place an X next to the appropriate answers)

In-Home Environment:	<input type="checkbox"/> Adequate	<input type="checkbox"/> Not Adequate
Utilities:	<input type="checkbox"/> Working	<input type="checkbox"/> Not Working
Fire Extinguisher:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Smoke Detector:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pest Problems:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Home Entrance/Exit:		

Emergency Evacuation Plan:

Durable Medical Equipment & Supplies:

Review of Systems: List DME in each system review section, as appropriate

Weight:

Neurological:

Respiratory:

Cardiovascular:

Genito-Urinary:

Gastro-Intestinal:

**In-Home Operations –
INTAKE MEDICAL SUMMARY (IMS):**IHO Region: ☐

North



South

Name:**Date of Visit:****SSN:****Case Manager:****Integumentary:****Musculoskeletal:****Psychosocial:****Review of Other Agencies, Programs, and Services Provided:**Report(s) obtained ☐ Yes ☐ No

List report(s) and date:

Issues/Plan for Resolution**Issues:****Plan for Resolution:**

(Please place an X next to the appropriate type(s) of referrals which apply)

Referrals		Date	Referrals		Date	Referrals		Date
Physical Therapy	<input type="checkbox"/>		Enterostomal Therapy	<input type="checkbox"/>		APS	<input type="checkbox"/>	
Occupational Therapy	<input type="checkbox"/>		Medical Social Worker	<input type="checkbox"/>		CPS	<input type="checkbox"/>	
Speech Therapy	<input type="checkbox"/>		AAC Device	<input type="checkbox"/>		L&C	<input type="checkbox"/>	
Other: <input type="checkbox"/>			Other: <input type="checkbox"/>					

Comments regarding referrals:**Justification for Program Level of Care and Level of Case Management**

Based upon the information contained in this report, the () facility alternative level of care (LOC) is

Request for change in Menu of Health Services: ☐ No ☐ Yes: If yes, update menu of services accordingly.**Print Name of NEII****Signature of NEII****Date report completed****Print Name/Title Second
Opinion-Reviewer of
LOC Determination****Signature of Second
Reviewer****Date report reviewed**

**In-Home Operations –
CASE MANAGEMENT REPORT (CMR):**IHO Region: ☐

North



South

Name:

Date of Visit:

SSN:

Case Manager:

Directions to Home**Home Visit Summary**

Purpose of Visit:

Persons Present:

Living Arrangements:

Chart and POT Review:

Staffing Issues:

Medical History:

Review of Home Safety
(please place an X next to the appropriate answers)In-Home Environment: ☐ Adequate ☐ Not AdequateUtilities: ☐ Working ☐ Not WorkingFire Extinguisher: ☐ Yes ☐ NoSmoke Detector: ☐ Yes ☐ NoPest Problems: ☐ Yes ☐ No

Home Entrance/Exit:

Emergency Evacuation Plan:

Durable Medical Equipment & Supplies:

Review of Systems: List DME in each system review section, as appropriate

Weight:

Neurological:

Respiratory:

Cardiovascular:

Genito-Urinary:

Gastro-Intestinal:

Integumentary:

Musculoskeletal:

Psychosocial:

**In-Home Operations –
CASE MANAGEMENT REPORT (CMR):**IHO Region: ☐

North



South

Name:

Date of Visit:

SSN:

Case Manager:

Review of Other Agencies, Programs, and Services Provided:Report(s) obtained ☐ Yes ☐ No

List report(s) and date:

Issues/Plan for Resolution**Issues:****Plan for Resolution:**

(Please place an X next to the appropriate type(s) of referrals which apply)

Referrals		Date	Referrals		Date	Referrals		Date
Physical Therapy	<input type="checkbox"/>	_____	Enterostomal Therapy	<input type="checkbox"/>	_____	APS	<input type="checkbox"/>	_____
Occupational Therapy	<input type="checkbox"/>	_____	Medical Social Worker	<input type="checkbox"/>	_____	CPS	<input type="checkbox"/>	_____
Speech Therapy	<input type="checkbox"/>	_____	AAC Device	<input type="checkbox"/>	_____	L&C	<input type="checkbox"/>	_____
Other: <input type="checkbox"/>		_____	Other: <input type="checkbox"/>		_____			

Comments regarding referrals:**Justification for Program Level of Care and Level of Case Management**

Based upon the information contained in this report, the () facility alternative level of care (LOC) is

Request for change in Menu of Health Services: ☐ No ☐ Yes: If yes, update menu of services accordingly.**Print Name of NEII****Signature of NEII****Date report completed****Print Name/Title Second
Opinion-Reviewer of
LOC Determination****Signature of Second
Reviewer****Date report reviewed**

**In-Home Operations –
INTAKE MEDICAL SUMMARY (IMS)
CASE MANAGEMENT REPORT (CMR) INSTRUCTIONS:**

IHO Region: ☐ North ☐ South

Name:

Date of Visit:

SSN:

Case Manager: Does not change if visit done by another NEII

Directions to Home

From the office or airport if appropriate, general directions to the beneficiary's home.

Home Visit Summary

Purpose of Visit:

Identify purpose - periodic LOC assessment; reevaluation of LOC due to changes in the beneficiary's condition; other.

Persons Present:

Include only those participating in the visit, the relationship of each participant & the person providing the information. Identify if additional information obtained from other sources, such as: IHO and/or home chart, observation, etc.

Living Arrangements:

Identify type of dwelling. Identify residents of home & relationship to the beneficiary. Describe living area for the beneficiary & where the waiver services are provided.

Chart and POT Review:

Review home chart for current POT, recent nurses notes, medication schedule, referral reports (MSW, PT, OT, ST), etc. Identify if the beneficiary is receiving waiver services as specified on the fully signed POT and per the MOHS by having the beneficiary/family **verbalize** the care and treatments actually being received. Note any differences in the care ordered and actually received.

Identify the POT adequacy based on beneficiary's **assessed** needs – does the POT identify ALL assessed waiver and non-waiver needs? If not, list POT concerns here & reference this section as item #1 in Issues/Plans for Resolution.

Staffing Issues:

If nursing care is provided, list actual frequency of RN Case Manager/supervisory visits, % of staffing coverage & nursing care issues. If unlicensed care is being provided, review availability of provider.

Medical History:

Brief Intake LOC information. Document with each visit justification for LOC. Do not delete previous LOC information.

This is a brief medical history – add only information which is different from past assessments

Example of new info: decannulization 01/01/01; tendon release 01/01/01; NIDDM 01/01/01

MD visits since last home visit - scheduled & unscheduled

Hospitalizations & ER visits over the past year or since last on-site visit - number, length, & reason

Allergies - include drug, food, environmental

Immunizations - optional

Review of Home Safety

In-Home Environment: [Adequate or Not Adequate]

Utilities: [Working, Not Working] Indicate backup generator and/or batteries

Fire Extinguisher: [Y/N]

Smoke Detector: [Y/N]

Pest Problems: [Y/N] if yes, briefly describe

Home Entrance/Exit:

List # of entrances/exits, # that are wheelchair accessible if applicable. Plan for resolution if access not adequate.

Emergency Evacuation Plan:

Evacuation plan posted in chart or home. Family & caregiver aware of plan? Include emergency response system if used.

Durable Medical Equipment & Supplies:

Name of DME provider and telephone number:

List DME in each system review section, as appropriate

Specify brand, quantities used, & serial numbers if applicable

**In-Home Operations –
INTAKE MEDICAL SUMMARY (IMS)
CASE MANAGEMENT REPORT (CMR) INSTRUCTIONS:**

IHO Region: ☐ North ☐ South

Name:

Date of Visit:

SSN:

Case Manager: Does not change if visit done by another NEII

Review of Systems: List DME in each system review section, as appropriate

Weight:

Amount; date taken

Identify if weight is stable or if there has been any significant and/or noticeable changes since the last visit (gain, loss)

Neurological:

Cognitive level - where information obtained

Developmental age (as determined by regional center, if consumer of a regional center)

Pain management issues; identify location and treatment

Seizure type, frequency, noted activity, date of last seizure; include medications & last prn given if applicable

Vision, hearing or speech issues

Speech Therapy

List devices and supplies, such as AAC devices, vagal nerve stimulator and availability of information re: use.

Respiratory:

Identify use of supplemental O2 (continuous or PRN); liters of flow; method of delivery (trach, mask, cannula)

Identify use of humidification & frequency of use

Type (oral, nasal, tracheal) and frequency of suctioning, person who cleans & cares for equipment

Frequency of respiratory treatments (scheduled or PRN), date of last PRN & reason

Last URI/pneumonia & treatment

Identify type of artificial ventilation equipment, settings & availability of back-up power

Ventilator status: number of hours on ventilator; ability to sprint off ventilator – length of time

Identify type of tracheostomy & tube size, frequency of trach care, person who changes & date of last change, how the trach cleaning is done (sterile or clean technique) & equipment used

Pulse oximeter use/frequency, # of desaturations in a day or week, interventions; date of last desaturation & intervention

Apnea monitoring, frequency of apneic episodes, date of last episode & intervention

Identify use of specialty equipment such as Phrenic Nerve Pacers, pneumatic belts, staff knowledge of device & availability of information regarding its use

List respiratory supplies and equipment; describe storage of equipment, such as oxygen tanks:

Cardiovascular:

Diagnosis & reason for cardiac medications

Cardiac monitoring

Pacemakers

BP/HR if there are issues

Need for I/O monitoring

Central venous lines, CVL location, frequency of site care, & person responsible for CVL care

List cardiac supplies:

Genito-Urinary:

Incontinent/continent

Indwelling or I&O catheters

Frequency of catheterization, catheter care, drainage bag changes & care

Identify urostomy, kidney problems, dialysis, dysreflexia, & menses

Date of last UTI & treatment

List GU supplies: (ex: adult briefs/diapers)

**In-Home Operations –
INTAKE MEDICAL SUMMARY (IMS)
CASE MANAGEMENT REPORT (CMR) INSTRUCTIONS:**

IHO Region: ☐ North ☐ South

Name:

Date of Visit:

SSN:

Case Manager: Does not change if visit done by another NEII

Gastro-Intestinal:

Nutrition: diet type, route and frequency

Gastric tube: type, size, frequency of care & tube change, who changes tube, date of last change

Gravity flow or pump used? Rate of flow? Residual checks? – if applicable

TPN and/or lipids: route, frequency, rate, person who administers

Incontinent/continent, bowel program, ostomy

Endocrine: treatment, who provides treatment, current issues/problems

List GI supplies:

Integumentary:

Identify all wounds - decubitus, rashes, incisions, stomas

If possible, view decubiti; ask staff present to assess and give you location, size, and stages - **NEII does not assess for staff**

Indicate source of verbal and written skin care documentation

Wound sensory assessment (pain assessment), care frequency, enterostomal therapy consults, if applicable

Turning surfaces available if compromised

List special beds, mattresses, or other skin care equipment (ex: special wheelchair pads or cushions).

Musculoskeletal:

Identify disability and functional abilities; ADLs

Identify if restraints are used; frequency and reason

Contractures – upper and/or lower. Mode of mobility

PT and/or OT consults – home treatment plan as applicable with last review/update by therapies

Orthotics and/or prosthetics - frequency and compliance in use

List adaptive equipment & supplies.

Psychosocial:

Ask the following questions to the beneficiary/family/primary caregiver:

Are they coping well with the waiver services as provided?

Are they satisfied with how the care is delivered?

Are the beneficiary's preferences for care considered?

Is the beneficiary receiving all services needed to stay safely in the home – waiver and non-waiver services?

What needs does the beneficiary have now that are not being taken care of?

Does bene/family need a Medical Social Services consult – if so, specify MSW needs

Identify primary caregiver(s) & back-up caregiver(s)

IHSS - # of hours per month; name of IHSS provider & relationship to beneficiary

Identify contingency plans in place to assure back-up care when usual care is not available and the lack of immediate care would pose a threat to health and welfare. (Example: emergencies due to severe weather, flood, fire, etc)

Ask the beneficiary/family if the back-up caregiver plan has ever been used and did it work?

Identify any activities outside the home environment which prevent the beneficiary's seclusion; include:

- PDHC or ADHC – # of hours/days per week spent in day health care
- School - name & type, # of hours/days per week attended; identify whether the home care provider accompanies
- Employment – type, access to medical care provider at work

Ask beneficiary (if applicable) if he/she has concerns with abuse, neglect or exploitation (of personal property or body)?

Ask beneficiary & caregivers (formal and informal) if they know how to report concerns of abuse, neglect or exploitation?

Ask beneficiary or family member during the first visit of the year if they received IHO's Client Satisfaction Survey. Was it returned to IHO? If not, explain survey and anonymity of results. Offer to send another one with reminder to return to IHO.

**In-Home Operations –
INTAKE MEDICAL SUMMARY (IMS)
CASE MANAGEMENT REPORT (CMR) INSTRUCTIONS:**

IHO Region: ☐ North ☐ South

Name: _____ **Date of Visit:** _____
SSN: _____ **Case Manager:** Does not change if visit done by another NEII

Review of Other Agencies, Programs, and Services Provided:

CCS - (child only); list therapies, treatments, etc. per CCS funds

Regional Center - name of RC, # of hours per month/quarter or service provided; # of parent-vendor hours

Medical transportation:

Non-medical transportation:

Consultation with specialists since last onsite visit, i.e. cardiologist, pulmonologist, neurologists

Report(s) obtained? ☐ NO ☐ YES – List report(s) and date:

Issues/Plan for Resolution

Issues:

Identify all issues relating to the care of the beneficiary, including changes in LOC

Identify if previous visit issues were resolved or not.

Identify information located in running record

Plan for Resolution:

Identify specific plans for each identified problem/issue & how each will be addressed

Specify each person responsible for the specific part of the resolution plan

Identify that "follow up actions resulting from these issues will be documented in the running record"

Referrals & date of referral

<input type="checkbox"/> Physical Therapy	Date _____	<input type="checkbox"/> Enterostomal Therapy	Date _____	<input type="checkbox"/> APS	Date _____
<input type="checkbox"/> Occupational Therapy	Date _____	<input type="checkbox"/> Medical Social Worker	Date _____	<input type="checkbox"/> CPS	Date _____
<input type="checkbox"/> Speech Therapy	Date _____	<input type="checkbox"/> AAC Device	Date _____	<input type="checkbox"/> L&C	Date _____
<input type="checkbox"/> Other:	Date _____	<input type="checkbox"/> Other:	Date _____		

Comments regarding referrals:

Justification for Program Level of Care and Level of Case Management

Based upon the information contained in this report, the (XXX) facility alternative level of care (LOC) is supported.

Identify dates of service, waiver services & # of units.

Document recommendations for change in facility alternative LOC with reference to appropriate Title 22 regulations.

Request for change in Menu of Health Services: ☐ NO ☐ YES; if yes, update menu of services accordingly.

Identify IHO Case Management level and list justification based on procedure manual.

Signature of NEII

Date report completed

Signature/Title of second opinion reviewer of LOC determination

[Can be supervisor, consultant, peer review, QA review]

Date report reviewed

**MEDI-CAL IN-HOME OPERATIONS
HOME AND COMMUNITY-BASED SERVICES
HOME AND SAFETY EVALUATION**

1 Beneficiary:					2 Date:	
3 HCBS Provider:						
4 Address:					5 Initial Evaluation: Yes No	
					6 Date of Previous Evaluation:	
7 Telephone #:						
8 Primary Care Giver:						
9 Relationship to beneficiary:					Comments:	
10 House:	Apartment:	Other:	Yes:	No:	N/A:	11
12 Beneficiary owned						
13 Family member owns						
14 Rented						
Structural Barriers:						
15 Exterior stairs Front: Rear:						16 Number of steps_____
17 Accessible to beneficiary						
18 Interior stairs						19 Number of steps_____
20 Accessible to beneficiary						
21 Ramp						22 Location:
23 Doorways adequate for beneficiary/wheelchair						
24 Hallways adequate for beneficiary/wheelchair						
25 Carpets are secure						
Utilities:						
26 Electricity functioning						
27 Electrical cords intact						
28 Electrical outlets secure						
29 Lighting adequate in beneficiary care areas						
30 Gas functioning						
31 Adequate temperature control for beneficiary						
32 Functioning telephone in beneficiary care area						
33 Smoke alarms functional						
34 Fire extinguisher is accessible						35 Location:
36 Adequate refrigeration for medicines						

**MEDI-CAL IN-HOME OPERATIONS
HOME AND COMMUNITY-BASED SERVICES
HOME AND SAFETY EVALUATION**

	Yes:	No:	N/A:	Comments:
Bathroom:				
37 Beneficiary can access bathroom	-			
38 Hot and cold running water				
39 Grab bars are present for patient use				
Evacuation Plan:				
40 Family verbalizes emergency evacuation plan				
Medical Gases:				
41 Oxygen/medical gas tanks are safely stored				
42 Signs posted indicating oxygen is in use				
Infestations				
43 Flying insects present/described by client				
44 Crawling insects present/described by client				
45 Rodent or other mammal infestations				
Summary:				
46 HOME IS ADEQUATE FOR THE DELIVERY OF				
HOME AND COMMUNITY BASED SERVICES.				
47 Signature of person completing document:			48 Date:	
49 Signature of beneficiary/representative:			50 Date:	
51 Use other side of document to diagram Emergency Evacuation Plan.				



State of California—Health and Human Services Agency
Department of Health Services



DIANA M. BONTÁ, R.N., Dr. P.H.
Director

GRAY DAVIS
Governor

**MEDI-CAL IN-HOME OPERATIONS
HOME AND COMMUNITY-BASED SERVICES (HCBS)
HOME SAFETY EVALUATION INSTRUCTION FORM**

This document is an Excel-based form that can be completed either electronically or manually. The **Comments** section may be used throughout the document to provide explanatory information as necessary. Please complete the form as follows:

General Information:

- Box 1: Name of beneficiary
Box 2: Today's date
Box 3: Name of HCBS provider – this may be a Home Health Agency, Independent Nurse Provider, or other individual in the role of Waiver Personal Care Service Provider
Box 4: Address of the beneficiary
Box 5: "Yes" or "No" to indicate whether or not this the first evaluation of this beneficiary
Box 6: If there is a previous evaluation, indicate the date of the evaluation
Box 7: Enter beneficiary's phone number
Box 8: Identifies the individual who is responsible for the beneficiary
Box 9: Identifies the relationship between the primary care giver and the beneficiary

Residence:

- Box 10: Check the appropriate box to indicate the nature of the residence: house or apartment.
Box 11: (If "Other" to 10) specify under Comments,
Box 12-14: Check the appropriate box to indicate "Yes", "No" or "N/A" for each question

Structural Barriers:

- Box 15: Indicate if there are stairs outside of the home, front access or rear access
Box 16: (If "Yes" to 15) indicate the number of stairs outside the home; indicate front and/or rear
Box 17: Accessible means the beneficiary is able to walk up and down the steps without assistance
Box 18: Indicate if there are stairs within the home
Box 19: (If "Yes" to 18) indicate the number of stairs within the home
Box 20: Accessible means is the beneficiary is able to walk up and down the steps without assistance
Box 21: Indicate if a ramp exists to facilitate wheelchair access
Box 22: (If "Yes" to 21) identify the location of the ramp
Box 23-25: Check the appropriate box to indicate "Yes", "No" or "N/A" for each question

Instructions for Page 2 of the Medi-Cal In-Home Operations Home and Community-Based Services Home Safety Evaluation Instruction Form:

Utilities:

- Box 26-34: Check the appropriate box to indicate "Yes", "No" or "N/A" for each question
- Box 35: Identify the room and location of the fire extinguisher
- Box 36: Indicate if there is adequate refrigeration capability for medicines as needed

Bathroom:

- Box 37: Indicate if the beneficiary is able to access the bathroom with or without adaptive equipment
- Box 38-39: Check the appropriate box to indicate "Yes", "No" or "N/A" for each question

Evacuation Plan:

- Box 40: Check the appropriate box to indicate "Yes", "No", or "N/A"

Medical Gases:

- Box 41: Check the appropriate box to indicate "Yes", "No", or "N/A"
- Box 42: (If yes to 41) check the appropriate box to indicate "Yes" or "No" and indicate the location of the signs under the comments section.

Infestations:

- Box 43-45: Check the appropriate box to indicate "Yes", "No", or "N/A" for each question. If yes to these boxes, provide explanation under comments.

Summary:

- Box 46: The summary statement reflects whether or not, in your judgment, the home is safe and adequate for the delivery of the proposed services under the Home- and Community-Based Services waiver.

Signatures:

- Box 47: Signature of the individual who fills out the document
- Box 48: Date of the document completion
- Box 49: Signature of the beneficiary or the person who signs for the beneficiary
- Box 50: Date of the signing of the document

Emergency Evacuation Plan:

- Box 51: The reverse side of this document is available to sketch the outline of the floor plan of the residence and to indicate the proposed emergency evacuation routes as indicated in Box 40.
Or, you may attach a copy of the emergency plan to this document.

MENU OF HOME AND COMMUNITY-BASED SERVICES WAIVER SERVICES (MOHS) FORM

Beneficiary Last Name:	_____	Beneficiary First Name:	_____
SSN:	_____	DOB:	_____
IHO Nurse Case Manager:	_____	Date:	_____

SUMMARY OF COST NEUTRALITY

Non-Waiver Program Costs:		Daily	Monthly	Annually ¹
Institution Rate	(FACTOR G)	\$ _____	\$ _____	\$ _____
Ancillary Rate	(FACTOR G')	\$ _____	\$ _____	\$ _____
TOTAL	(FACTOR G+G')	\$ _____	\$ _____	\$ _____

Waiver Program Costs²:

Waiver Program Costs	(FACTOR D)	\$ _____	\$ _____	\$ _____
State Plan Costs	(FACTOR D')	\$ _____	\$ _____	\$ _____
TOTAL	(FACTOR D+D')	\$ _____	\$ _____	\$ _____

COST NEUTRALITY

THE NON-WAIVER PROGRAM COST TOTAL (FACTOR G + G')
MUST BE EQUAL TO OR LESS THAN
THE WAIVER PROGRAM COST TOTAL (FACTOR D + D')

COST NEUTRALITY MET? _____

Y = Yes

N = No

(based upon review of authorized services)

- 1 Includes one-time costs
2 Cost of living increase of 3% added to cost annually

MENU OF HOME AND COMMUNITY-BASED SERVICES WAIVER SERVICES (MOHS) FORM					
Beneficiary Last Name: _____		Beneficiary First Name: _____			
SSN: _____		DOB: _____			
IHO Nurse Case Manager: _____		Date: _____			
Waiver Program Costs:	Unit Cost	No. of Units	Daily	Monthly	Annually
Case Management:					
Home Health Agency	\$45.43				
Private Duty Nursing Agency	\$35.77				
Individual Nurse Provider	\$35.77				
Individual Licensed Professional	\$35.77				
Professional Organization	\$45.43				
Service Coordination:					
Home Health Agency	\$35.77				
Private Duty Nursing Agency	\$35.77				
Individual Nurse Provider	\$35.77				
Individual Licensed Professional	\$35.77				
Professional Organization	\$35.77				
Personal Care Services (PCS):					
Home Health Agency	\$10.52				
Individual Provider	\$9.56				
Respite:					
INP – RN	\$31.94				
INP – RN - Shared	\$35.13				
INP – RN - Supervision	\$35.77				
INP - LVN	\$24.42				
INP - LVN – Shared	\$26.86				
Home Health Agency - PCS	\$10.52				
Individual Provider - PCS	\$9.56				
HHA – RN	\$40.57				
HHA – RN – Shared	\$44.63				
HHA – LVN	\$29.41				
HHA – LVN – Shared	\$32.35				
HHA – CHHA	\$18.90				
HHA - CHHA -Shared	\$20.79				
PDNA - RN	\$31.94				
PDNA – RN - Shared	\$35.13				
PDNA – LVN	\$24.42				
PDNA – LVN - Shared	\$26.86				
Nursing Facility					
Environmental Accessibility Adaptations: 1	\$5,000.00				
Personal Emergency Response Systems:					
1 One-time costs	\$31.51				

Revised 1/23/02

MENU OF HOME AND COMMUNITY-BASED SERVICES WAIVER SERVICES (MOHS) FORM

Beneficiary Last Name: _____	Beneficiary First Name: _____
SSN: _____	DOB: _____
IHO Nurse Case Manager: _____	Date: _____

Waiver Program Costs Continued:	Unit Cost	No. of Units	Daily	Monthly	Annually
Private Duty Nursing:					
INP – RN	\$31.94				
INP – RN - Shared	\$35.13				
INP – RN - Supervision	\$35.77				
INP – LVN	\$24.42				
INP – LVN - Shared	\$26.86				
HHA – RN	\$40.57				
HHA – RN – Shared	\$44.63				
HHA – LVN	\$29.41				
HHA – LVN – Shared	\$32.35				
HHA – CHHA	\$18.90				
HHA – CHHA - Shared	\$20.79				
PDNA – RN	\$31.94				
PDNA – RN - Shared	\$35.13				
PDNA – LVN	\$24.42				
PDNA – LVN - Shared	\$26.86				
CLHF – Type A					
Family Training:					
Home Health Agency - RN	\$45.43				
Individual Provider – RN	\$35.77				
Private Duty Nursing Agency - RN	\$35.77				
Utility coverage: (Average cost per month)					
Home Health Agency	\$45.00				
Private Duty Nursing Agency	\$45.00				
Individual Provider – RN	\$45.00				
Individual Licensed Professional	\$45.00				
Professional Organization	\$45.00				
Waiver Program Costs (FACTOR D)	\$	\$	\$	\$	\$

MENU OF HOME AND COMMUNITY-BASED SERVICES WAIVER SERVICES (MOHS) FORM

Beneficiary Last Name: _____	Beneficiary First Name: _____
SSN: _____	DOB: _____
IHO Nurse Case Manager: _____	Date: _____

STATE PLAN COSTS ESTIMATE

State Plan Costs:	Unit Cost	No. of Units	Daily	Monthly	Annually
EPSDT Private Duty Nursing Services	\$		\$	\$	\$
Adult Day Health Care	\$		\$	\$	\$
Pediatric Day Health Care	\$		\$	\$	\$
Personal Care Services under IHSS	\$		\$	\$	\$
Oxygen, Gas	\$		\$	\$	\$
Oxygen, Liquid	\$		\$	\$	\$
Oxygen, Concentrators	\$		\$	\$	\$
Suction Equipment, Portable	\$		\$	\$	\$
Suction Equipment, Stander	\$		\$	\$	\$
Ventilator	\$		\$	\$	\$
Wheelchair, Custom	\$		\$	\$	\$
Wheelchair, Manual	\$		\$	\$	\$
Walkers	\$		\$	\$	\$
Transportation	\$		\$	\$	\$
Bed	\$		\$	\$	\$
Anti-decubitus Supplies	\$		\$	\$	\$
Gloves, Disposable	\$		\$	\$	\$
Incontinent Supplies	\$		\$	\$	\$
Nebulizer	\$		\$	\$	\$
Formula	\$		\$	\$	\$
Family Therapy	\$		\$	\$	\$
Home Health Agency Services:					
Skilled Nursing Care Services	\$		\$	\$	\$
MSW Visits	\$		\$	\$	\$
Physical Therapy	\$		\$	\$	\$
Occupational Therapy	\$		\$	\$	\$
Speech Therapy	\$		\$	\$	\$
Other	\$		\$	\$	\$
Total State Plan Costs (FACTOR D')					
	\$	\$	\$	\$	\$

MENU OF HOME AND COMMUNITY-BASED SERVICES WAIVER SERVICES (MOHS) FORM

Beneficiary Last Name: _____	Beneficiary First Name: _____
SSN: _____	DOB: _____
IHO Nurse Case Manager: _____	Date: _____

Waiver Program Costs Continued:	Unit Cost	No. of Units	Daily	Monthly	Annually
Private Duty Nursing:					
INP – RN	\$31.94				
INP – RN - Shared	\$35.13				
INP – RN - Supervision	\$35.77				
INP – LVN	\$24.42				
INP – LVN - Shared	\$26.86				
HHA – RN	\$40.57				
HHA – RN – Shared	\$44.63				
HHA – LVN	\$29.41				
HHA – LVN – Shared	\$32.35				
HHA – CHHA	\$18.90				
HHA – CHHA - Shared	\$20.79				
PDNA – RN	\$31.94				
PDNA – RN - Shared	\$35.13				
PDNA – LVN	\$24.42				
PDNA – LVN - Shared	\$26.86				
CLHF – Type A					
Family Training:					
Home Health Agency - RN	\$45.43				
Individual Provider – RN	\$35.77				
Private Duty Nursing Agency - RN	\$35.77				
Utility coverage: (Average cost per month)					
Home Health Agency	\$45.00				
Private Duty Nursing Agency	\$45.00				
Individual Provider – RN	\$45.00				
Individual Licensed Professional	\$45.00				
Professional Organization	\$45.00				
Waiver Program Costs (FACTOR D)					
	\$	\$	\$	\$	\$

Appendix D-4, Freedom of Choice and Fair Hearing**a. Freedom of Choice and Fair Hearing**

1. When an individual is determined to likely require a level of care indicated in item 2 of this request, for a period of at least 365 consecutive days, the individual or his/her legal representative will be:
 - a. informed of any feasible alternatives under the waiver
 - b. given the choice of either institutional or home and community-based services
2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request or who are denied the service(s) of their choice or the provider(s) of their choice.
3. The following are attached to this Appendix:
 - a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing;
 - b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;
 - c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and
 - d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

b. Freedom of Choice Documentation

Specify where copies of this form are maintained:

A beneficiary or, if appropriate, their representative shall evidence the choice to receive home and community-based services by signing a HCBS "Freedom of Choice" form. Completed forms will be retained in the beneficiary's records at the designated Medi-Cal office.

Attachment to Appendix D-4**Procedures For Freedom Of Choice**

The procedures for informing the eligible recipients of the feasible alternatives available under the waiver, and allowing recipients to choose either institutional or home and community-based services, consists of provision of verbal information to the beneficiary or, if appropriate, the authorized representative prior to obtaining their signature on the HCBS Freedom of Choice form.

Procedures For Fair Hearing

The procedures for informing an eligible recipient or their authorized representative of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E, are pre-printed on the Notice of Action form which is used to notify the beneficiary or his/her representative when a request for a HCBS service is not approved as requested or denied. The Notice of Action document for the initial request is called the Jackson v. Rank (JvR) form. When HCBS waiver services have been previously authorized and are now reduced or terminated by DHS, a Notice of Action form will be forwarded to the beneficiary. This Notice of Action document is called the Frank v. Kiser (FvK) form.

Attachment Form to Appendix D-4

- **Freedom of Choice and Informing Notice**
- **Notice of Action and/or Request for a Fair Hearing**

DEPARTMENT OF HEALTH SERVICES

700 NORTH TENTH STREET, SUITE 102

P.O. BOX 942732

SACRAMENTO, CA 94234-7320

(916) 324-5361



February 11, 2002

**MEDI-CAL HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVER
INFORMING NOTICE**

«Bene Name»

«Bene_Address»

«Bene_City_ST_Zip»

Dear «Salutation»:

«BENE_NAME»

The Department of Health Services' (the Department's), Medi-Cal In-Home Operations (IHO) has received a request for HCBS waiver services for **«Bene_NAME»** under the Nursing Facility (NF) **<A/B or Subacute>** waiver.

The purpose of this HCBS Informing Notice is to describe the waiver program and to outline the roles and responsibilities of the beneficiary and primary caregiver, the primary care physician, the HCBS waiver service provider(s), and IHO. Ultimately, our goal is to inform all interested individuals regarding what is needed from them in order to ensure the successful development and implementation of a safe home program under the NF **<A/B or Subacute>** waiver.

The HCBS waivers are sets of services designed for Medi-Cal beneficiaries to assist them in remaining in their homes as an alternative to care in a licensed health care facility, also known as the **"institutional alternative"**. In order for IHO to authorize these services, there must be a medical need for the services. Additionally, the cost of the requested service(s) shall not exceed the costs Medi-Cal would have paid to the health care facility alternative should the service(s) not have been provided in the home setting. The licensed health care facility alternative is determined by IHO and is based upon criteria outlined in regulations, as well as in the requested waiver program. The services available under the NF **<A/B or Subacute>** waiver include case management, private duty nursing, personal care services, and respite.

In order for IHO to authorize initial or ongoing NF **<A/B or Subacute>** waiver services, the following information is needed:

1. A Treatment Authorization Request (TAR), which is the primary way to request HCBS waiver services. TARs are submitted to IHO by the selected HCBS primary waiver service provider. This formal request may also be submitted in a different written format, as required by IHO, when the HCBS primary provider is an unlicensed individual or a nontraditional Medi-Cal provider;



Do Your Part to Help California Save Energy To learn more about saving energy, visit the following web site:

<http://www.consumerenergycenter.org/flex/index.html>

2. A plan of treatment (POT), which is the physician's order for the HCBS waiver services. The POT outlines the needs of the beneficiary and **must include all waiver and nonwaiver services needed by the individual in order to be maintained safely in the home setting**. This would include services provided by the identified HCBS waiver service provider and any other provider type; and,
3. Medical justification for the HCBS waiver services. This information should support the medical need for the services and assist IHO in determining the appropriate health care facility alternative.

NOTE: Initial and ongoing requests for HCBS waiver services must demonstrate a medical need for the services and be cost-effective in order to be authorized or reauthorized. Changes in medical needs may impact the future level of care and amount of services that may be authorized by IHO. Should IHO determine a change in the authorization of services is necessary, the beneficiary will be notified in writing about the change and why it was made. This notification will include appeal rights for the beneficiary, as required by law.

ROLES AND RESPONSIBILITIES FOR:

1. The Beneficiary and Primary Caregivers

- The beneficiary must identify a support network system, such as a primary caregiver, to support him or her in the event the HCBS waiver service provider is not able to provide the total number of authorized services.
- The beneficiary must be Medi-Cal eligible with no restrictions on the amount of services he or she is eligible to receive. The physician must document that the beneficiary has medical needs that can be safely provided for in the home.
- A home must be maintained that ensures the health and safety of the beneficiary, as well as the HCBS waiver services provider(s). This would include: an area to accommodate the medical equipment and supplies, an appropriate area for cleaning the supplies, adequate lighting and temperature control, an area free from pest infestations, working utilities, a functional telephone, an adequate entrance into the home, and an emergency plan in the event of a home evacuation.

- The beneficiary and/or primary caregiver must assist the HCBS waiver service provider(s) and the primary care physician in the development of the POT that outlines the home program and the needs of the individual.
- The beneficiary and/or the primary caregiver must comply with the developed POT in order to ensure a successful home program.
- The beneficiary and/or the primary caregiver must work cooperatively with IHO in identifying services to assist in maintaining the individual in the home. This would include needed services from the NF **<A/B or Subacute>** waiver within program cost limits, Medi-Cal, and other community or government funded programs.
- The beneficiary and/or the primary caregiver must participate actively in the home care program. For the primary caregiver, this would include being trained in the care needs of the beneficiary, being present in the event the HCBS waiver service provider is not available, and following any additional physician's orders, if applicable, to ensure the health, safety, and welfare of the beneficiary.
- The beneficiary and/or the primary caregiver must contact the HCBS waiver service provider(s) or the IHO nurse case manager regarding any issues or concerns with the home program that may impact the delivery of services.
- The beneficiary and/or the primary caregiver must contact the HCBS waiver services provider(s) and IHO as soon as possible, in the event there are changes with the availability of the primary caregiver. This notification is necessary in the event the changes in the availability of the caregiver impact the safety, health, and welfare of the beneficiary.
- The beneficiary and/or the primary caregiver must notify the HCBS waiver service provider(s) and IHO as soon as possible when changing residences. This is necessary so that IHO can assist as needed in linking the beneficiary with other potential providers of services in the new community. The IHO nurse case manager may also request a home visit of the new residence for evaluation of health and safety, as appropriate.
- The beneficiary and/or the primary caregiver must seek out a new HCBS waiver service provider in the event the current HCBS waiver service provider is not able to meet the needs of the beneficiary. Depending upon the availability of a new HCBS waiver service provider, there may be a waiting period of 30 days or more before the change is effective. The beneficiary may contact the IHO nurse case manager for assistance in locating a new HCBS waiver service provider.

2. The Primary Care Physician must:

- Provide the following information to the HCBS waiver service provider in a timely manner: written beneficiary-specific orders, a complete and accurate written medical record that includes current medical diagnoses, a history and physical assessment with a systems review, and other medical documentation as requested.
- Participate actively with the beneficiary and the HCBS waiver service provider in developing and/or writing a POT that is individualized for the needs of the beneficiary, and includes all needed services under the NF **<A/B or Subacute>** waiver, Medi-Cal, and other services provided by public or private programs.
- Actively assist the HCBS waiver service provider and the beneficiary with any needed revisions to the POT.
- Provide written documentation that the beneficiary's medical condition is stable and that the provision of services under the NF **<A/B or Subacute>** waiver can be provided safely in the home.
- Provide written documentation that the medical needs of the beneficiary are of such a nature that the beneficiary would require care in a licensed health care facility, if the beneficiary cannot be safely maintained in the home.
- Work cooperatively with the HCBS waiver service provider and IHO in providing updated medical information as requested to substantiate both initial and ongoing medical necessity for the services requested.
- Accept full responsibility for providing and coordinating the beneficiary's medical needs for the home care program, as documented in a written statement to be provided in a format satisfactory to IHO.

3. The HCBS Waiver Services Provider must:

- Sign and have on file with IHO an HCBS Waiver Provider Agreement. This agreement must be signed, dated and returned to IHO before HCBS waiver services can be authorized.
- Assess for the availability of a support network system for the beneficiary with the onset of services and periodically thereafter and no less than twice a year. In the event the beneficiary does not have this support network system or if changes are needed the HCBS provider of services will assist the beneficiary in developing and or maintaining this system.

Be licensed and/or certified and appropriately trained as outlined in the NF **<A/B or Subacute>** waiver. The provider may be a current Medi-Cal provider or a provider under the HCBS waiver. In the event the provider is identified to provide only HCBS waiver services, the provider must meet all applicable Medi-Cal criteria. The HCBS waiver service provider must maintain compliance with all applicable state and federal requirements, including but not limited to:

- Development of a POT, based upon the primary care physician's written orders for the home program. The POT is to include that the beneficiary is on the NF **<A/B or Subacute>** waiver, all waiver services authorized by the Department and all other services being provided to the beneficiary while under the NF **<A/B or Subacute>** waiver. These services may also include Medi-Cal related services, such as equipment, supplies, transportation, and Adult Day Health Care; services through California Children's Services, such as therapies; regional center services, such as respite; services provided through other public entities, such as In-Home Supportive Services (IHSS), and private entities.
- Maintain documentation, subject to the Department's review and approval, acknowledging compliance with the developed POT.
- Evaluate and document that the beneficiary's residence is appropriate and adequate for the delivery of waiver services, which will ensure both the health and safety of the beneficiary and the provider of service(s). This documentation shall be in a format acceptable to the Department and will include the following:
 - Assessment of the area in which the beneficiary will be cared for and the area(s) to be used for the maintenance, cleaning, and storing of supplies and equipment;
 - Assessment of primary and back-up utility services, communication systems, fire safety systems and devices, such as grounded electrical outlets, smoke detectors, a fire extinguisher, and a functional telephone;
 - Development of an emergency back-up plan appropriate to the area of residence and the types of emergencies that are known to occur in the area. This plan requires that a party be designated to notify the local utility companies, the emergency response systems, the fire department, and any local rescue organizations that the beneficiary has special medical needs that may require assistance in case of an emergency.

- Notify the Department in a timely manner of any changes reported to the Department of Licensing and Certification (California Code of Regulations, Title 22, Division 3, Section 74667). This notification is required by all HCBS providers who are licensed and certified home health agencies and applies to changes that impact the health, safety, or welfare of the beneficiary.

4. The Department (IHO) will:

- Work cooperatively with the beneficiary and/or the primary caregiver, the HCBS waiver service provider(s), the primary care physician, and all other providers of Medi-Cal services to help ensure a successful home program. This would also include collaboration on linking the beneficiary with other programs and supports, and problem resolution, as warranted.
- Assist as warranted in the identification of supports needed to ensure the health and safety of this individual while under this waiver.
- Conduct home visits that may or may not be announced to assess the home program and any issues related to the home program. Unannounced visits shall be conducted, as deemed necessary by the Department, to assess the health and safety of the beneficiary.
- Modify, reduce, deny, or terminate NF **<A/B or Subacute>** waiver services should any one of the following occur:
 - The cost of the requested service(s) exceeds the cost of the identified institutional alternative and the beneficiary and/or the primary caregiver does not agree to a reduction in the requested services in order to maintain program cost-neutrality;
 - The beneficiary loses Medi-Cal eligibility;
 - The beneficiary dies;
 - The beneficiary or his/her authorized representative elects in writing to terminate NF **<A/B or Subacute>** waiver services;
 - The beneficiary moves from the geographical area in which the NF **<A/B or Subacute>** waiver services were being authorized, and in the new area there are providers of services but no provider has agreed to render waiver services to the beneficiary;

- The beneficiary's condition is unstable as demonstrated by repeated, unplanned hospitalizations;
- The beneficiary's condition improves to the point that he/she no longer meets the medical eligibility criteria for the NF **<A/B or Subacute>** waiver services, i.e., the level of care has changed;
- The beneficiary and/or the primary caregiver refuse to comply with the primary care physician's orders on the POT and the Department determines that such compliance is necessary to assure the health and safety of the beneficiary;
- The beneficiary and/or the primary caregiver do not cooperate in attaining or maintaining the plan of treatment goals;
- The identified support network system and/or the primary caregiver, can not be identified, is not able, or is no longer willing or available to assume the responsibility to act as a back-up for the beneficiary;
- The home assessment fails to demonstrate an environment that supports the beneficiary's health and safety or is otherwise not conducive to the provision of HCBS waiver services. The home safety assessment will be determined through a home safety evaluation completed by the HCBS provider;
- The beneficiary and/or the primary caregiver ***decline the case management services when electing to receive "waiver personal care services" as the sole waiver service;***
- The HCBS waiver service provider is unwilling or unable to provide the amount of authorized services as required by the beneficiary's treatment plan and/or physician's order. This inability to provide services may impact the quality of the service(s) provided. Therefore, if requested to do so by the beneficiary and/or the authorized representative, the Department shall assist with the authorization process for the beneficiary at the otherwise appropriate licensed health care facility, until another HCBS waiver service provider accepts the responsibility for providing services in the home setting; and,
- Any documented incidence of noncompliance by any party with the requirements of this agreement that poses a threat to the health or safety of the beneficiary, and/or any failure to comply with all regulatory requirements.

«Bene Name»
Page 8
February 11, 2002

Questions regarding this notice should be directed in writing to the following address:

Department of Health Services
Medi-Cal In-Home Operations
700 North Tenth Street, Suite 102
P.O. Box 942732
Sacramento, CA 94234-7320

Telephone inquiries should be directed to the following number: (916) 324-1020.

Your interest as a participant in the NF **<A/B or Subacute>** waiver is appreciated.

Sincerely,

René Mollow, MSN, R.N., Chief
Quality Assurance Unit
In-Home Operations

cc: «NE II_Name», R.N.
Nurse Evaluator II
In-Home Operations

«Author_Initials»:«Typist_Initials»

DEPARTMENT OF HEALTH SERVICES
IN-HOME OPERATIONS SOUTHERN REGION
 700 North 10th Street, Suite 102
 P.O. Box 942732
 Sacramento, CA 94234-7320

Se le puede enviar una traducción de esta forma si la pide por escrito a la oficina que se menciona a la izquierda.

NOTICE OF ACTION: (FvK1)
Denial Constituting a Termination

**Reduction of Previously
 Approved Services**

or
 To: _____

Date: _____
 TAR No.: _____
 Expiration Date: _____
 Medi-Cal No.: _____
 Facility: _____

Medi-Cal In-Home Operations has taken the following action with respect to services requested by your doctor or other Medi-Cal provider. Provider name and address: _____

- ___ 1. Denied further Medi-Cal payment for _____ services effective _____. The Medi-Cal program previously approved payment for these services for the period _____ through _____.
 ___ 2. Denied some portion of the services requested. The Medi-Cal program previously approved payment for services for the period _____ through _____ as follows: _____. Approval of these services has been modified beginning _____ as follows: _____.

The reason and legal basis for this decision is as follows:

- ___ 1. Your current medical condition and/or medical needs as described by your medical provider do not meet the definition of "medical necessity" as set forth in Title 22, California Code of Regulations, Section 51303(a).
 ___ 2. The service requested does not meet the requirements for lowest cost item or service that meets your medical needs covered by the Medi-Cal program as set forth in Title 22, California Code of Regulations, Section 51003(f).
 ___ 3. Other (explain and cite regulations.) _____

If you do not agree with the above action, you or your authorized representative have the right to request a State Hearing within ninety (90) days of the date of this notice. Please see the back of this notice for information on how to request a State Hearing.

If you request a State Hearing before the expiration date at the top of this notice or within ten (10) days of the date of this notice, whichever is later, Medi-Cal will continue to approve the requested services until a State Hearing decision is made.

This notice does not affect your eligibility for Medi-Cal. You will continue to receive your Medi-Cal card and the covered Medi-Cal services for which you have a medical need.

 in-Home Operations Representative

DEPARTMENT OF HEALTH SERVICES
IN-HOME OPERATIONS SOUTHERN REGION

Se le puede enviar una traducción de esta forma si la pide por escrito a la oficina que se menciona a la izquierda

700 North 10th Street, Suite 102
P.O. Box 942732
Sacramento, CA 94234-7320


NOTICE OF ACTION: (FvK2)
Termination or Reduction
Prior to Expiration

To: _____

 Medi-Cal No: _____

Date: _____
 TAR No: _____

Medi-Cal In-Home Operations previously approved _____ services for payment by the Medi-Cal programs requested by the following provider: _____. Services approved for payment have been re-evaluated and the field office has determined that approval for these services must be:

___ Reduced effective _____ as follows: _____.

___ Terminated effective _____.

The reason for this decision is that _____.

The legal basis for this decision is as follows:

- ___ 1. Your current medical condition and/or medical needs as described by your medical provider do not meet the definition of "medical necessity" as set forth in Title 22, California Code of Regulations, Section 51003.
- ___ 2. The service requested does not meet the requirements for lowest cost item or service that meets your medical needs covered by the Medi-Cal program as set forth in Title 22, California Code of Regulations, Section 51003(f).
- ___ 3. Other (Explain and cite regulations.) _____

If you do not agree with the above action, you or your authorized representative have the right to request a State Hearing within ninety (90) days of the date of this notice. Please see the back of this notice for information on how to request a State Hearing.

If you request a State Hearing before the expiration date at the top of this notice or within ten (10) days of the date of this notice, whichever is later, Medi-Cal will continue to approve the requested services until a State Hearing decision is made.

This notice does not affect your eligibility for Medi-Cal. You will continue to receive your Medi-Cal card and the covered Medi-Cal services for which you have a medical need.

Cc:

 Medi-Cal Field Office Representative

White Copy – Beneficiary; Canary – Provider; Pink – Field Office; Goldenrod – Headquarters

DEPARTMENT OF HEALTH SERVICES
IN-HOME OPERATIONS SOUTHERN REGION
 700 North 10th Street, Suite 102
 P.O. Box 942732
 Sacramento, CA 94234-7320

Se le puede enviar una traducción de esta forma si la pide por escrito a la oficina que se menciona a la izquierda.

NOTICE OF ACTION: (JvR3)

To: _____

Date: _____
 TAR No.: _____
 Medi-Cal No.: _____
 Expiration Date: _____
 Facility: _____

Medi-Cal In-Home Operations has taken the following action with respect to services requested by your doctor or other Medi-Cal provider. Provider name and address: _____

- ___ 1. Denied further Medi-Cal payment for _____ services effective _____. The Medi-Cal program previously approved payment for these services for the period _____ through _____.
- ___ 2. Denied some portion of the services requested. The Medi-Cal program previously approved payment for services for the period _____ through _____ as follows: _____. The Medi-Cal program has approved these services beginning _____ as follows: _____.

The reason and legal basis for this decision is as follows:

- ___ 1. Your current medical condition and/or medical needs as described by your medical provider do not meet the definition of "medical necessity" as set forth in Title 22, California Code of Regulations, Section 51303(a).
- ___ 2. The service requested does not meet the requirements for lowest cost item or service that meets your medical needs covered by the Medi-Cal program as set forth in Title 22, California Code of Regulations, Section 51003(f).
- ___ 3. Other (explain and cite regulations.) _____

If you do not agree with the above action, you or your authorized representative have the right to request a State Hearing within ninety (90) days of the date of this notice. Please see the back of this notice for information on how to request a State Hearing. Also, please see the attached notice concerning additional appeal rights that you have.

This notice does not affect your eligibility for Medi-Cal. You will continue to receive your Medi-Cal card and the covered Medi-Cal services for which you have a medical need.

 In-Home Operations Representative

White Copy – Beneficiary; Canary – Provider; Pink – Field Office; Goldenrod – Headquarters

YOUR HEARING RIGHTS

To Ask For a State Hearing

The right side of this sheet tells how.

- You only have 90 days to ask for a hearing.
- The 90 days started the day after we mailed this notice.
- You have a much shorter time to ask for a hearing if you want to keep your same benefits.

To Keep Your Same Benefits While You Wait For a Hearing

You must ask for a hearing before the action takes place.

- Your Cash Aid will stay the same until your hearing.
- Your Medi-Cal will stay the same until your hearing.
- Your Food Stamps will stay the same until the hearing or the end of your certification period, whichever is earlier.
- If the hearing decision says we are right, you will owe us for any extra cash aid or food stamps you got.

To Have Your Benefits Cut Now

If you want your Cash Aid or Food Stamps cut while you wait for a hearing, check one or both boxes.

☐ Cash Aid

☐ Food Stamps

To Get Help

You can ask about your hearing rights or free legal aid at the state information number.

Call toll free: 1-800-952-5253
If you are deaf and use TDD call: 1-800-952-8349

If you don't want to come to the hearing alone, you can bring a friend, an attorney or anyone else. You must get the other person yourself.

You may get free legal help at your local legal aid office or welfare rights group.

Other Information

Child Support: The District Attorney's office will help you collect child support even if you are not on cash aid. There is no cost for this help. If they now collect child support for you, they will keep doing so unless you tell them in writing to stop. They will send you any current support money collected. They will keep past due money collected that is owed to the county.

Family Planning: Your welfare office will give you information when you ask.

Hearing File: If you ask for a hearing, the State Hearing Office will set up a file. You have the right to see this file. The State may give your file to the Welfare Department, the U.S. Department of Health and Human Services and the U.S. Department of Agriculture. (W & I Code Section 10950)

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page and send or take it to:

Administrative Adjudications Division
State Department of Social Services
744 P Street, Mail Station 19-37
Sacramento, CA 95814

Los Angeles County residents (only) send to:
Fair Hearings Section
P.O. Box 10280
Glendale, CA 91209

You may also call 1-800-952-5253.

HEARING REQUEST

I am requesting a state hearing because of a Medi-Cal related action by the In-Home Operations Southern Region Office.

Here's why: _____

I will bring this person to the hearing to help me
(name and address, if known):

I need an interpreter at no cost
to me. My language or dialect is: _____

My name: _____

Address: _____

Phone: _____

My Signature: _____

Date: _____

YOUR HEARING RIGHTS

To Ask For a State Hearing

The right side of this sheet tells how.

- You only have 90 days to ask for a hearing.
- The 90 days started the day after we mailed this notice.
- You have a much shorter time to ask for a hearing if you want to keep your same benefits.

To Keep Your Same Benefits While You Wait For a Hearing

You must ask for a hearing before the action takes place.

- Your Cash Aid will stay the same until your hearing.
- Your Medi-Cal will stay the same until your hearing.
- Your Food Stamps will stay the same until the hearing or the end of your certification period, whichever is earlier.
- If the hearing decision says we are right, you will owe us for any extra cash aid or food stamps you got.

To Have Your Benefits Cut Now

If you want your Cash Aid or Food Stamps cut while you wait for a hearing, check one or both boxes.

☐ Cash Aid

☐ Food Stamps

To Get Help

You can ask about your hearing rights or free legal aid at the state information number.

Call toll free: 1-800-952-5253
If you are deaf and use TDD call: 1-800-952-8349

If you don't want to come to the hearing alone, you can bring a friend, an attorney or anyone else. You must get the other person yourself.

You may get free legal help at your local legal aid office or welfare rights group.

Other Information

Child Support: The District Attorney's office will help you collect child support even if you are not on cash aid. There is no cost for this help. If they now collect child support for you, they will keep doing so unless you tell them in writing to stop. They will send you any current support money collected. They will keep past due money collected that is owed to the county.

Family Planning: Your welfare office will give you information when you ask.

Hearing File: If you ask for a hearing, the State Hearing Office will set up a file. You have the right to see this file. The State may give your file to the Welfare Department, the U.S. Department of Health and Human Services and the U.S. Department of Agriculture. (W & I Code Section 10950)

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page and send or take it to:

Administrative Adjudications Division
State Department of Social Services
744 P Street, Mail Station 19-37
Sacramento, CA 95814

Los Angeles County residents (only) send to:
Fair Hearings Section
P.O. Box 10280
Glendale, CA 91209

You may also call 1-800-952-5253.

HEARING REQUEST

I am requesting a state hearing because of a Medi-Cal related action by the In-Home Operations Office.

Here's why: _____

I will bring this person to the hearing to help me
(name and address, if known):

I need an interpreter at no cost
to me. My language or dialect is: _____

My name: _____

Address: _____

Phone: _____

My Signature: _____

Date: _____

APPENDIX E, PLAN OF CARE**Appendix E-1, Plan of Care Development****a. PLAN OF CARE DEVELOPMENT**

1. The following individuals are responsible for the preparation of the plans of care/plan of treatment (POT):

 X Registered nurse, licensed to practice in the State who is either:

- a. Employed by the HHA/PDNA; or
- b. Under the direction of a licensed physician

 Licensed practical or vocational nurse, acting within the scope of practice under State law

 X Physician (M.D. or D.O.) licensed to practice in the State who is also the primary care physician of the beneficiary.

 X Social Worker, a individual licensed professional MFCC, Clinical Psychologist, LCSW or a professional entity or organization made up of MFCCs, Clinical Psychologists, or LCSWs. (See page B-19 for qualifications)

 Case Manager

 X Other (specify):

Registered Nurse, licensed to practice in the State and who is an employee of DHS-MCOD to consult with the provider of waiver services in the development and review of the POT.

The development of the POT will include input from the beneficiary and, if appropriate, the authorized representative.

2. Copies of written plans of care/plan of treatment will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.

 X At the Medicaid agency central office or the designated Medi-Cal office.

 At the Medicaid agency county/regional offices

 X By case managers who are employed by DHS-MCOD.

- ☒ By the agency specified in Appendix A
- ☐ By consumers
- ☒ Other (specify): Copies of the POT will be maintained by the waiver service provider at their place of business.

3. The plan of care/plan of treatment is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

- ☐ Every 3 months
- ☐ Every 6 months
- ☐ Every 12 months

- ☒ Other (specify): At the time of the initial request and for each subsequent reauthorization. Services under the NF A/B Waiver may be reauthorized for up to 180 days.

A POT is required to be submitted by the waiver service provider with the initial and all reauthorization requests for services. The POT is submitted to the designated Medi-Cal office along with the TARs. The POTs are reviewed and updated at the provider level, as specified in established regulations and in a manner consistent with applicable license and certification requirements necessary for the delivery of services. Additionally, when the DHS-MCOD case manager conducts the semiannual home visit, the POT will be reviewed. This home visit and POT review will be documented on the "Case Management Report" form.

Appendix E-2, Medicaid Agency Approval

a. Medicaid Agency Approval

The following is a description of the process by which the plan of care/plan of treatment is made subject to the approval of the Medicaid agency:

The POT is submitted to the appropriate Medi-Cal office with a Treatment Authorization Request (TAR) as part of the initial request for services. The POT is updated at the time of reauthorization, when there are changes in the condition of the beneficiary or when there are updates or changes made to the authorized services. The POT is developed and submitted to the DHS-MCOD nurse case managers for review of continued medical necessity and compliance with requirements outlined in Title 22, CCR, Sections 51003, 51337 and 74697.

The TAR for reauthorization of services is submitted every 180 days by the authorized waiver service(s) provider. Each request for reauthorization of services is accompanied by a current POT and MOHS plan. Prior authorization, reauthorization or approval granted by a designated Medi-Cal consultant is required in advance of the rendering any NF A/B Waiver service.

b. Statutory Requirements and Copy of Plan of Care

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.
2. A copy of the plan of care/plan of treatment form to be utilized in this waiver is attached to this Appendix. All HCBS waiver providers will be required to utilize the POT developed by MCOD-IHO.
 - a. The HCFA-485, "Home Health Certification and Plan of Care" may on an interim basis be used for the plan of care/plan of treatment. The primary waiver service provider in collaboration should complete the document with the beneficiary and the primary care physician. The amount, duration and frequency of all prescribed services – waiver and non-waiver – will be on the plan of care/plan of treatment.

For purposes of providers who use the Form HCFA-485, the amount, duration and frequency of all prescribed services – waiver and non-waiver - will be listed in item #21 of the Form HCFA-485, labeled "Orders for Discipline and Treatments". The plan of care is submitted to the appropriate DHS-MCOD office when services are first requested and thereafter for reauthorization of continued services. The plan of care is to be developed using criteria outlined in Title 22, CCR, Section 74697.

The DHS-MCOD staff reviews these documents for appropriate care

planning for the beneficiary as well as delivery of services by the appropriate provider types based upon acceptable standards within the nursing community. Any necessary revisions are discussed with the provider of service, the physician and beneficiary as needed.

- b. The providers who use the Form HCFA-485 will be instructed to write “Non applicable” in item # 26 of the form.

Attachments to Appendix E-2

- **Plan of Treatment and Instructions for Completion**



1. BENEFICIARY INFORMATION

2. PROVIDER INFORMATION

3. PRIMARY CARE PHYSICIAN

***Note: The treatment period may be less than the 180 days depending upon licensure or certification requirements of rendering provider.**

In-Home Operations Section
Home and Community-Based Services Branch
Electronic Plan of Treatment
Beneficiary's Name:
Treatment Period:

FROM

TO

4. MEDICAL INFORMATION – Include ICD-9 codes where appropriate.
Please add additional pages as needed.

Beneficiary's Primary Diagnosis _____ Date of onset: ____ / ____ / ____
Primary Diagnosis _____ ICD-9 _____

If secondary diagnosis - please include _____ Date of onset: ____ / ____ / ____
Secondary Diagnosis _____ ICD-9 _____

Please list other diagnosis here _____ Date of onset: ____ / ____ / ____
Other Diagnosis _____ ICD-9 _____

Please list other diagnosis here _____ Date of onset: ____ / ____ / ____
Other Diagnosis _____ ICD-9 _____

Prognosis: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

5. MEDI-CAL HOME AND COMMUNITY-BASED PROGRAM
Please check all that apply.

- ☐ Nursing Facility (NF) A/B Waiver ☐ NF Subacute (SA) Waiver ☐ In-Home Medical Care (IHMC) Waiver
☐ Early Periodic, Screening, Diagnosis and Treatment (EPSDT) ☐ Pediatric Day Health Care (PDHC)

6. Level of Care (LOC)
Please check only one.

NOTE: The LOC determination will be made by the Medi-Cal In-Home Operations Section and provided to the provider.

- ☐ Acute ☐ ICF/DDH ☐ NF-B (DP)
☐ Adult Subacute ☐ ICF/DDN ☐ Pediatric Subacute non-ventilator dependent
☐ ICF/DD ☐ NF-A ☐ Pediatric Subacute ventilator dependent
☐ NF-B

In-Home Operations Section
Home and Community-Based Services Branch
Electronic Plan of Treatment
Beneficiary's Name:
Treatment Period:

FROM

TO

7.**WAIVER SPECIFIC SERVICES**

**Please check all that apply and enter the appropriate frequency key code.
(Only complete this section if enrolled in a HCBS Waiver program.)**

Service**Frequency Key Code:**

D=Daily	W=Weekly
Y=Yearly	M=Monthly
O=Other	

If other
please describe below

<input type="checkbox"/> Case Management	Please Choose One	If other, please describe _____
<input type="checkbox"/> Environmental Accessibility Adaptations	Please Choose One	If other, please describe _____
<input type="checkbox"/> Family Training	Please Choose One	If other, please describe _____
<input type="checkbox"/> Personal Emergency Response Systems	Please Choose One	If other, please describe _____
<input type="checkbox"/> Private Duty/Individual/Shared Nursing Care	Please Choose One	If other, please describe _____
<input type="checkbox"/> Certified Home Health Aide Services	Please Choose One	If other, please describe _____
<input type="checkbox"/> Respite	Please Choose One	If other, please describe _____
<input type="checkbox"/> Utility Services	Please Choose One	If other, please describe _____
<input type="checkbox"/> Personal Care Services under the Waiver	Please Choose One	If other, please describe _____
<input type="checkbox"/> Waiver Service Coordination	Please Choose One	If other, please describe _____

In-Home Operations Section
Home and Community-Based Services Branch
Electronic Plan of Treatment
Beneficiary's Name:
Treatment Period:

FROM

TO

8. NON-WAIVER SERVICES

Include all applicable services and frequency. May include those services funded by Medi-Cal, Regional Centers, California Children's Services, Independent Living Centers, In-Home Supportive Services, Department of Rehabilitation, Department of Mental Health, Private Insurance, and/or school-based services.

**Examples include: Adult Day Health Care, Pediatric Day Health Services, Medical Therapy Program, Housing Referrals, Social Service Referrals, and Vocational Rehabilitation.
Please add additional pages as needed.**

Please use additional pages as needed

9. MEDICATION PLAN FOR HOME PROGRAM

Space for additional medications provided on Page 5.

Allergies:	List any beneficiary allergies, please use additional paper if needed	Reaction (if known):	Please list the reaction from allergies
Medication:	_____	Dose: _____	Route: _____ Frequency: _____
Medication:	_____	Dose: _____	Route: _____ Frequency: _____
Medication:	_____	Dose: _____	Route: _____ Frequency: _____
Medication:	_____	Dose: _____	Route: _____ Frequency: _____
Medication:	_____	Dose: _____	Route: _____ Frequency: _____
Medication:	_____	Dose: _____	Route: _____ Frequency: _____
Medication:	_____	Dose: _____	Route: _____ Frequency: _____
Medication:	_____	Dose: _____	Route: _____ Frequency: _____
Medication:	_____	Dose: _____	Route: _____ Frequency: _____

In-Home Operations Section
Home and Community-Based Services Branch
Electronic Plan of Treatment
Beneficiary's Name:
Treatment Period:

FROM

TO

9a.	ADDITIONAL MEDICATIONS
------------	-------------------------------

Medication: _____	Dose: _____	Route: _____	Frequency: _____
Medication: _____	Dose: _____	Route: _____	Frequency: _____
Medication: _____	Dose: _____	Route: _____	Frequency: _____
Medication: _____	Dose: _____	Route: _____	Frequency: _____
Medication: _____	Dose: _____	Route: _____	Frequency: _____
Medication: _____	Dose: _____	Route: _____	Frequency: _____
Medication: _____	Dose: _____	Route: _____	Frequency: _____
Medication: _____	Dose: _____	Route: _____	Frequency: _____
Medication: _____	Dose: _____	Route: _____	Frequency: _____
Medication: _____	Dose: _____	Route: _____	Frequency: _____
Medication: _____	Dose: _____	Route: _____	Frequency: _____
Medication: _____	Dose: _____	Route: _____	Frequency: _____
Medication: _____	Dose: _____	Route: _____	Frequency: _____
Medication: _____	Dose: _____	Route: _____	Frequency: _____
Medication: _____	Dose: _____	Route: _____	Frequency: _____
Medication: _____	Dose: _____	Route: _____	Frequency: _____
Medication: _____	Dose: _____	Route: _____	Frequency: _____
Medication: _____	Dose: _____	Route: _____	Frequency: _____
Medication: _____	Dose: _____	Route: _____	Frequency: _____
Medication: _____	Dose: _____	Route: _____	Frequency: _____

Who gives the medications to the patient?

ie: self, family, nurse, caregiver

In-Home Operations Section
Home and Community-Based Services Branch
Electronic Plan of Treatment
Beneficiary's Name:
Treatment Period:

FROM

TO

10. NUTRITIONAL REQUIREMENTS

Please include type of diet, method of feeding, amount and frequency.

Please use additional pages as needed

11. TREATMENT PLAN FOR HOME PROGRAM:

Include all needed services, frequency, and duration of service and provider(s) of service(s).

Space for additional orders provided on Page 7.

Please use additional pages as needed

In-Home Operations Section
Home and Community-Based Services Branch
Electronic Plan of Treatment
Beneficiary's Name:
Treatment Period:

FROM

TO

**11a. TREATMENT PLAN FOR HOME PROGRAM – CONTINUED
ADDENDUM**

Please use additional pages as needed

In-Home Operations Section
Home and Community-Based Services Branch
Electronic Plan of Treatment
Beneficiary's Name:
Treatment Period:

FROM

TO

12.**FUNCTIONAL LIMITATIONS**

**Please describe functional limitations per the physician order within each category.
Please add additional pages as needed.**

☐ No limitations noted.

MOTOR: May include limitations with walking and/or gross motor movement.

Please use additional pages as needed

☐ No limitations noted.

SELF HELP: May include limitations with activities of daily living such as bathing, toileting, eating, and dressing.

Please use additional pages as needed

☐ No limitations noted.

COMMUNICATION/SENSORY May include limitations with hearing, speech, and sight.

Please use additional pages as needed

In-Home Operations Section
Home and Community-Based Services Branch
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Beneficiary's Name:
Treatment Period:

FROM

TO

13.**ACTIVITIES**

Include permitted activities per the physician order such as up with assistance, complete bedrest, up as tolerated, use of adaptive equipment such as wheelchair, walker, etc.

☐ No restrictions on activities.

Please use additional pages as needed

Safety precautions in use:

☐ Seizure precautions

☐ Universal precautions

☐ Other:

Rehabilitation Potential:

☐ Good

☐ Fair

☐ Poor

14.**MENTAL STATUS**

May include information related to behavior and/or cognition such as aggression, depression, agitation, confusion, and developmental disabilities.

☐ No limitations noted – oriented to name, date, place and time.

Please use additional pages as needed

In-Home Operations Section
Home and Community-Based Services Branch
Electronic Plan of Treatment
Beneficiary's Name:
Treatment Period:

FROM

TO

15. DURABLE MEDICAL EQUIPMENT**Include all types of equipment used, provider of equipment, and funding source (if known).**

TYPE	PROVIDER NAME	FUNDING SOURCE

16. MEDICAL SUPPLIES**Include all types of supplies, provider of supplies, and funding source (if known).**

TYPE	PROVIDER NAME	FUNDING SOURCE

In-Home Operations Section
Home and Community-Based Services Branch
Electronic Plan of Treatment
Beneficiary's Name:
Treatment Period:

FROM

TO

17. THERAPIES/REFERRALS

**Check all that apply and please include date the referral was made and why.
If therapy is ongoing, please indicate the current progress/status in Section 20.**

<input type="checkbox"/> Physical Therapy	____ / ____ / ____	Referral Reason _____
Date		
<input type="checkbox"/> Occupational Therapy	____ / ____ / ____	Referral Reason _____
Date		
<input type="checkbox"/> Speech Therapy	____ / ____ / ____	Referral Reason _____
Date		
<input type="checkbox"/> Enterostomal Therapy	____ / ____ / ____	Referral Reason _____
Date		
<input type="checkbox"/> Medical Social Worker	____ / ____ / ____	Referral Reason _____
Date		
<input type="checkbox"/> Nutritionist	____ / ____ / ____	Referral Reason _____
Date		
<input type="checkbox"/> Other/List	____ / ____ / ____	Referral Reason _____
Date		
<input type="checkbox"/> Other/List	____ / ____ / ____	Referral Reason _____
Date		
<input type="checkbox"/> Other/List	____ / ____ / ____	Referral Reason _____
Date Referral Reason		

18. TREATMENT GOALS/DISCHARGE PLAN

Please check only one.

- ☐ Upon completion of treatment plan, the beneficiary will be able to function independently and maintain self safely in the home setting.
- ☐ Upon completion of this treatment plan, the beneficiary will continue to need
- ☐ Minimal ☐ Moderate ☐ Maximum support to be maintained safely in the home setting.

Describe specific goals and discharge plan as related to the identified needs:

In-Home Operations Section
Home and Community-Based Services Branch
Electronic Plan of Treatment
Beneficiary's Name:
Treatment Period:

FROM

TO

19. TRAINING NEEDS FOR BENEFICIARY/FAMILY

- ☐ No training needs have been identified for the beneficiary and/or the family during this treatment period.
- ☐ Yes, there are training needs for the beneficiary and/or family during the treatment period.

(If yes boxed checked, please describe the training needs and name of the provider)

Please use additional pages as needed

20. SUMMARY OF BENEFICIARY STATUS DURING THIS TREATMENT PERIOD

Please use additional pages as needed

In-Home Operations Section
Home and Community-Based Services Branch
Electronic Plan of Treatment
Beneficiary's Name:
Treatment Period:

FROM

TO

21. After completing please print and obtain original signatures. Keep the original and mail a copy to the attention of the appropriate IHO Regional Office and the Medi-Cal In-Home Operations assigned Nurse Case Manager.

Beneficiary Signature_____
/ /
Date_____
Primary Caregiver Signature (as applicable)_____
/ /
Date_____
Physician Signature_____
/ /
Date_____
Provider Signature_____
/ /
Date_____
Provider Signature_____
/ /
Date_____
Provider Signature_____
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Date_____
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Provider Signature_____
/ /
Date

Medi-Cal In-Home Operations (IHO) Section

Home and Community-Based Services (HCBS) Branch

Instructions for the Plan of Treatment (POT) Document

**MEDI-CAL IN-HOME OPERATIONS (IHO) SECTION
HOME AND COMMUNITY-BASED SERVICES (HCBS) BRANCH
INSTRUCTIONS FOR THE PLAN OF TREATMENT (POT) DOCUMENT**

The HCBS POT is a Word-based document that can be filled out either electronically or manually. This POT can be used for Medi-Cal beneficiaries receiving services through one of the HCBS Waivers administered by IHO and/or Private Duty Nursing (PDN) services through the Medi-Cal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. Below are general directions for each section of the form.

The **Comments** section may be used throughout the document to provide explanatory information as necessary. The completed POT must obtain original signatures from the beneficiary or their legal representative, Primary Care Physician, and for HCBS waiver beneficiaries, all the HCBS Waiver service provider(s), i.e., personal caregiver, Home Health Agency (HHA), Independent Nurse Provider (INP), etc. or for EPSDT beneficiaries all the INPs. Once all signatures have been obtained, keep the original and return a signed copy of this document to the appropriate IHO Regional Office.

Step 1 (For the electronic version only.)

(Note: For the manual version go to step 2)

a. **Unlock** the document:

- Go to the **View** menu, click on **Toolbars** and then click on **Forms**.
- A ✓ should appear next to **Forms**.
- The Forms toolbar will appear with the **LOCK** button turned on. In the “Locked” mode, the button will have a light gray background.
- Click on the **LOCK** button. In the “Unlocked” mode the button will have a medium gray background.
- b. Complete the header at the top of page 2 by entering the beneficiary’s name and the treatment period “from and to” dates.
- How to access the header (2 methods):
 1. Go to page 2. Using your mouse, double click on the header and enter the information. To exit this function, using your mouse, double click in any area out side of the header. This information will auto-fill on the subsequent pages.

or

2. Go to the **View** menu, click on **Hheader and Footer** and scroll down to page 2. Enter the information in the Header. To exit this function, go back to the menu bar. Click on **View**. Click on the ✓ next to **Hheader and Footer**.

- c. **Lock** the document. Click on the **LOCK** button. The button background will change to light gray.

- d. Complete the POT as instructed below in step 3.

Helpful hints for using the electronic version.

This document has been developed with check boxes, drop-down menus, and locked fields.

- **Do not use the *ENTER/RETURN* key, as it will alter the formatting and disrupt the spacing throughout the document.**
- Check boxes. The check boxes can be marked with an "X" by placing the cursor over the box and single clicking it using the mouse.
- Drop-down menus. The drop-down menus can be accessed by placing the cursor over the box, single clicking it with the mouse and selecting the appropriate response. The only drop-down menus present on the POT are found in section 7. **Waver Specific Services.**
- Locked fields. The locked fields appear as gray shaded areas and are preset to tab through the document. You can use your mouse to maneuver around the document.
- Be sure that the **LOCK** button is turned on. If the **LOCK** button is turned off before completion, the form will not work properly.
- Spell Check. In order to spell check the document, the POT must be entirely completed and the **LOCK** button must be turned **OFF**. Go to the **Tools** menu and click on **Spelling and Grammar**. Once the spell check is complete, you can choose to save the document by going to the **File** menu and clicking on **Save As....**

<p>IMPORTANT: If the LOCK button is turned back ON after any information has been entered on the POT, it will delete all of the information you have entered on the POT.</p>
--

Step 2 (Manual version)

- a. On pages 2 through 13, complete the header by entering the beneficiary's name and the treatment period "from and to" dates.
- b. Complete the POT as instructed below in step 3.

Step 3: Completing the HCBS Branch POT (Electronic and Manual versions)

Section 1: Beneficiary Information

Please complete as indicated. The **medical record number** of the beneficiary is optional and is for the provider's use for filing purposes. The **primary language** may include the primary caregiver's primary language, if different from that of the beneficiary.

Section 2: HCBS Provider Information

Please complete as indicated. The **provider** name is the name of the agency or individual who is primarily responsible for the services described in the POT. This would include the HHA, Case Manager (CM), Professional Corporation (PC), or the lead Individual Nurse Provider (INP) LVN for beneficiaries receiving EPSDT Private Duty Nursing (PDN) services without R.N. Case Management. The **treatment period** may vary depending upon licensure and/or certification requirements of the provider.

Section 3: Primary Care Physician

Please complete as indicated. The **Primary Care Physician** is the physician signing the POT.

Section 4: Medical Information

Please complete as indicated. Include **ICD-9 codes** or diagnosis codes where appropriate. The **“other”** section may be used if there are other diagnoses pertaining to this beneficiary.

You may contact the MD to obtain the diagnosis and ICD9 codes.

For the **prognosis**, please check only one of the boxes (excellent, good, fair, or poor).

Section 5: Medi-Cal Home and Community-Based Program

Please check all the appropriate programs for which services are being requested. You may contact the IHO Case Manager for the appropriate program information.

Section 6: Level of Care (LOC)

The **LOC determination will be made by the Medi-Cal In-Home Operations Section** and provided to the provider (HHA, CM, PC or INP). Please check **only one box**—once information is provided.

Section 7: Waiver Specific Services

* **Note:** This section is not completed for beneficiaries who are only receiving EPSDT PDN services.

Please complete as indicated. All the **Waiver Specific Services** are listed in this section. Please check all of the services the beneficiary is utilizing. If you are using the document electronically, please click on the arrow under the **Frequency Key Code**, and double-click the appropriate **Key Code**. If **“other”** is used, then please describe.

Section 8: Non-Waiver Services

For beneficiaries enrolled in one of IHO's HCBS Waivers, federal regulations require that all non-waiver services the beneficiary is receiving be described in their POT. The description of the services includes the amount, frequency and who provides the service. **Non-waiver services** may include services funded by Medi-Cal, Regional Centers, California Children's Services, Independent Living Centers, In-Home Supportive Services, Department of Rehabilitation, Department of Mental Health, Private Insurance, and/or school-based services. **Examples:** Adult Day Health Care (ADHC), Pediatric Day Health Care (PDHC), Social Services Referrals, Medical Therapy Program, Housing Referrals, Respite and Vocational Rehabilitation.

Section 9: Medication Plan for Home Program

Please complete as indicated. This includes prescription and non-prescription medications. Space for additional medications is provided on Page 5 of the POT.

Section 9a: Medication Plan for Home Program – Additional Page**Section 10: Nutritional Requirements**

Please describe nutritional requirements for the beneficiary as ordered by the physician. Please indicate type of diet, method of feeding, amount, and frequency.

Section 11: Treatment Plan for Home Program

MD orders must identify all services rendered by the provider.

Please list/describe all services provided including:

- The provider of services.
- The provider type.
- The amount and frequency of the services.
- The type of services provided.

Space for additional orders can be provided on Page 7 of the POT.

Section 11a: Treatment Plan for Home Program – Continued**Section 12: Functional Limitations**

Please describe functional limitations as per the physician's order within each category. If **"no"** limitations are noted, please check the appropriate box and proceed to Section 13.

Motor (examples: amputation, contracture, paralysis, ambulation, partial weight bearing, crutches, cane, wheelchair, walker)

Self-help (examples: incontinent of bowel/bladder, independent at home)

Communication/Sensory (examples: hearing, speech, legally blind, glasses)

Section 13: Activities

Please describe activities of the beneficiary as per the physician's order. (Examples: Endurance, dyspnea with exertion, complete bedrest, bedrest BRP, up as tolerated, exercises prescribed). If **"no"** restrictions on activities are noted, please check the appropriate box and proceed to Section 14.

Section 14: Mental Status

Please summarize the mental status of the beneficiary. (Examples: comatose, forgetful, depressed, disoriented, lethargic, agitated, developmentally delayed). If **"no"** limitations are noted, please check the appropriate box and proceed to Section 15.

Section 15: Durable Medical Equipment

Please list all types of equipment used, providers of equipment, and funding sources such as Medi-Cal, private insurance, Medicare. *(if known)*.

Section 16: Medical Supplies

Please list all types of supplies, providers of supplies, and funding sources such as Medi-Cal, private insurance, Medicare. *(if known)*.

Section 17: Therapies/Referrals

Please check all types of therapy that apply, the date each referral was made, and the reason(s) why the referral was made. If ***therapy is ongoing***, please indicate the current progress/status in Section 20. If the type of therapy is ***not listed***, please use the ***other/list***.

Section 18: Treatment Goals/Discharge Plan

Please check the appropriate box. If you select the 2nd box, you must describe the level of support needed, i.e., Minimal, Moderate, or Maximum.

Describe specific goals and discharge plans that are identified in the POT, i.e., beneficiary will be able to self-direct caregivers in trach care, primary caregivers will be knowledgeable in diabetic management, or caregivers will be knowledgeable in pressure relief.

Section 19: Training Needs for Beneficiary/Family

Please check ***only one*** box for training needs. If you choose ***“yes”***, please use the area provided to describe the training needs of the beneficiary/family and list the name of the provider(s).

Section 20: Summary of Beneficiary Status during this Treatment Period

Please summarize the ***status of the beneficiary*** during this treatment period for the POT. This area may also be used, as stated in Section 17, to describe current progress/status of ongoing therapy. Each INP is to provide a summary of the care they provided and the overall status of the beneficiary. Include the beneficiary's response to their POT and any significant changes.

Signature Section

Please complete the POT Form, then print, and ***obtain original signatures*** from the following:

- The physician who oversees beneficiary's home program
- The beneficiary or their legal representative
- Primary Caregiver (i.e. parent, spouse, family member)
- All providers of HCBS Waiver services (this can include: HHA, Waiver Personal Care Providers, INPs, Professional Corporation, and the CM)
- ALL INPs for beneficiaries who are only receiving INP services through the Medi-Cal EPSDT benefit

Keep the original, make a copy, and ***return the copy by mail to the attention*** of the appropriate IHO Regional Office, and assigned IHO Nurse Case Manager as listed below:

Name of IHO Nurse Case Manager
In-Home Operations Section
Department of Health Services
1501 Capitol Avenue, MS 4502
P.O. Box 997419
Sacramento, CA 95899-7419

Name of IHO Nurse Case Manager
In-Home Operations Section
Department of Health Services
311 South Spring Street, Suite 313
Los Angeles, CA 90013-1211

APPENDIX F, AUDIT TRAIL**Appendix F-1, Description of Process****a. Description of Process**

1. As required by Sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.
2. As required by Section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.
3. Method of payments (check one):
 - ☐ Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).
 - ☒ Payments for most, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.
 - ☐ Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.
 - ☐ Other (Describe in detail):

b. Billing and Process and Records Retention

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only:
 - a. When the individual was eligible for Medicaid waiver payment on the date of service;
 - b. When the service was included in the approved plan of care;
 - c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the

individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

☐ Yes

☒ No. These services are not included in this waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

☐ All claims are processed through an approved MMIS.

☒ MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

c. Payment Arrangements

1. Check all that apply:

☒ The Medicaid agency will make payments directly to providers of waiver services.

☒ The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.

☐ The Medicaid agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims.

☐ Providers may voluntarily reassign their right to direct payments to the following governmental agencies (specify): Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method:

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.

Attachment to Appendix F**Billing Process and Records Retention**

The State of California assures CMS that the Department will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver and it will maintain and make available to the U.S. Department of Health and Human Services, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

California Medicaid Management Information System (CA-MMIS):

All HCBS waiver services are subject to the requirements established under the CA-MMIS system. CA-MMIS provides two basic functions to assure financial accountability of the waiver program:

1. CA-MMIS serves as the automated claims processing system for HCBS waiver claims. CA-MMIS verifies recipient Medi-Cal eligibility, waiver enrollment, and payment only to Medi-Cal waiver service providers; and
2. CA-MMIS produces the data from paid waiver claims to produce the data for the HCFA-372 Report sections specific to waiver recipients and expenditures. This automated claims payment processing system contains information on the number of recipients by level of service, and actual expenditures for all waiver services.

This automated billing system will be maintained by the State's fiscal intermediary. The automated billing system will follow standard Medicaid billing procedure. In addition to the normal claims processing the automated billing system will contain the following elements:

1. Unique service codes including definitions and rates for each service provided under the waiver.
2. Edits and audits to assure that only authorized waiver service providers bill for services. CA-MMIS subjects all claims to duplicate billing checks, and CA-MMIS has the ability to suspend claims for conflicting or overlapping codes.
3. Edits that prevent waiver services from being claimed while a recipient is institutionalized.

All HCBS waiver services will require prior authorization through the State's standard utilization review system using the Treatment Authorization Request (TAR) system.

The Medi-Cal Operations Division may manually processes some claims for HCBS waiver services in the following instances:

1. Congregate living health facility providers
2. Environmental Accessibility Adaptations

3. Personal Emergency Response Systems
4. Individual Nurse Providers
5. Individual Licensed Professionals: MFCC, LCSW, Clinical Psychologist, others with similar qualifications
6. Entities or organizations using Licensed Professionals – who are not traditional Medi-Cal providers
7. Unlicensed caregivers

Claims are verified for accuracy by appropriate IHO staff and are submitted to the Department's Financial Management Branch, Accounting Section for payment to the HCBS waiver service provider. At its discretion, the State may elect to amortize the cost of environmental accessibility adaptations under this waiver and/or high cost durable medical equipment under the State Plan benefit.

The Department has entered into an Interagency Agreement with the Department of Social Services (DSS) to provide payment to the providers of Waiver Personal Care Services described in the NFA/B Waiver. DSS processes payments for and are reimbursed by individual counties for the state plan of personal care service hours which can be authorized up to a maximum of 283 hours per month. The payment system used by DSS, Case Management Information Payrolling System (CMIPS), is currently used for the payment of State Plan Personal Care Services. This system was developed by Electronic Data Systems (EDS), the current fiscal intermediary for Medi-Cal payments. The functions of this system includes the capability to capture assessment information, issue Notices of Actions, interfacing with the Medi-Cal Eligibility Data System (MEDS) and to generate reports to state staff on fiscal and statistical information. Tapes are exchanged from this system with Medi-Cal to reconcile payments for personal care services. The Department reimburses DSS for making payments for the authorized Personal Care Service hours under the HCBS waiver. (See page A-5 of this request for a description of personal care services under the NFA/B Waiver.)

Quality Control/Quality Assurance

Quality control/quality assurance reviews will be performed periodically by DHS-MCOD Quality Assurance Unit to ensure that waiver services have received prior authorization, been appropriately billed, and are cost effective. Any billing discrepancies will be reported to the Department's Payment Systems Division, which is responsible for oversight of the State's fiscal intermediary.

APPENDIX G, FINANCIAL DOCUMENTATION**Appendix G-1, Composite Overview****Cost Neutrality Formula**

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g., hospital and nursing facility), complete an Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE: **NURSING FACILITY/COMBINED NF A AND NF B**
CALENDAR

YEAR	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
1	\$23,386	\$9,471	\$35,743	\$1,173
2	\$23,804	\$9,755	\$37,744	\$1,208
3	\$25,485	\$10,048	\$39,807	\$1,244
4	\$25,155	\$10,349	\$42,067	\$1,281
5	\$25,795	\$10,659	\$44,439	\$1,319

LEVEL OF CARE: **NURSING FACILITY/LEVEL A**
CALENDAR

YEAR	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
1	\$11,837	\$9,471	\$24,551	\$1,173
2	\$10,948	\$9,755	\$25,908	\$1,208
3	\$9,811	\$10,048	\$27,326	\$1,244
4	\$9,041	\$10,349	\$28,884	\$1,281
5	\$8,397	\$10,659	\$30,514	\$1,319

LEVEL OF CARE: **NURSING FACILITY/LEVEL B**
CALENDAR

YEAR	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
1	\$23,595	\$9,471	\$35,948	\$1,173
2	\$24,014	\$9,755	\$37,936	\$1,208
3	\$24,831	\$10,048	\$40,011	\$1,244
4	\$25,428	\$10,349	\$42,296	\$1,281
5	\$26,094	\$10,659	\$44,680	\$1,319

Factor C, Number of Unduplicated Individuals ServedLEVEL OF CARE: NURSING FACILITY/NF A/B

	CALENDAR YEAR	UNDUPLICATED INDIVIDUALS	COMMUNITY DEEMING	INSTITUTIONAL DEEMING
1	2001/2002	450	300	150
2	2002/2003	560	360	200
3	2003/2004	670	420	250
4	2004/2005	780	480	300
5	2005/2006	890	540	350

EXPLANATION OF FACTOR C:

Check one:

 X The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year. A chart of the expected phase-in/phase-out for the five-year period is attached.

 The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform CMS in writing of any limit which is less than factor C for that waiver year.

Attachment To Factor C, 5 Year Phase-In, Phase Out

The previous NF waiver #0139.90.01 had an enrollment cap of 546 unduplicated individuals in the last operating fiscal year. Based on the IHO database as of March 2001 NF A or B Level of Care made up 46.5% of the NF Waiver or 258 beneficiaries. Of the 258 beneficiaries, 2% are NF Level A and 98% are NF Level B. The IHO waiting list for NF Level A or B has approximately 100 NF Level A or B level of care beneficiaries pending services.

The previous Model-NF waiver #40136.91.R1 had an enrollment of cap of 200 unduplicated individuals in the last operating fiscal year. Based on the IHO database as of March 2001 NF A/B level of care made up 44.5% of the Model NF waiver or 89 beneficiaries.

ASSUMPTIONS FOR FACTOR C:

- Growth is anticipated to be 103 the first year and 110 beneficiaries annually thereafter.
- Withdrawals from the program is anticipated to be 18 beneficiaries per year
- Any requests for services that exceed the approved enrollment cap will be placed on a waiting list

Annually the program will conduct a review to determine if an amendment should be submitted to CMS requesting additional enrollment slots to ensure reasonable movement of those individuals on the waiting list

YEAR 2001-02

Level A					Level B				Combined			
Month	Users	Phase Out	Phase in	Undup.	Users	Phase Out	Phase In	Undup	Grand Total Users		Grand Total Undup	
Jul	6	0	0	6	345	1	11	356	351		362	
Aug	6	0	0	6	355	2	11	366	361		372	
Sep	6	0	1	7	364	1	10	374	370		381	
Oct	7	0	0	7	373	1	10	383	380		390	
Nov	7	0	0	7	682	2	10	392	389		399	
Dec	7	0	0	7	390	1	10	400	397		407	
Jan	7	1	0	7	399	2	10	409	406		416	
Feb	6	0	0	6	407	2	10	417	413		423	
Mar	6	0	0	6	415	1	10	425	421		431	
Apr	6	0	1	7	424	2	10	434	430		441	
May	7	0	0	7	432	3	10	442	439		449	
Jun	7	0	1	8	439	0	3	442	446		450	
Total	7	1	3	9	439	18	115	536	446		545	

YEAR 2002-03

Level A					Level B				Combined			
Month	Users	Phase Out	Phase in	Undup.		Users	Phase Out	Phase In	Undup	Grand Total Users		Grand Total Undup
Jul	8	0	0	8		442	1	11	453	450		461
Aug	8	0	0	8		452	2	11	463	460		471
Sep	8	0	1	9		461	1	11	472	469		481
Oct	9	0	0	9		471	1	11	482	480		491
Nov	9	0	0	9		481	2	11	492	490		501
Dec	9	0	0	9		490	1	11	501	499		510
Jan	9	1	0	9		500	2	10	510	509		519
Feb	9	0	0	8		508	2	10	518	517		526
Mar	9	0	0	8		516	1	10	526	525		534
Apr	9	0	0	8		525	2	10	535	534		543
May	9	0	0	8		533	2	10	543	542		551
Jun	9	0	1	9		541	0	10	551	550		560
Total	9	1	2	10		541	17	126	667	550		667

YEAR 2003-2004

Level A					Level B				Combined			
Month	Users	Phase Out	Phase in	Undup.		Users	Phase Out	Phase In	Undup	Grand Total Users		Grand Total Undup
Jul	9	0	0	9		551	1	11	562	560		571
Aug	9	0	0	9		561	2	11	572	570		581
Sep	9	0	1	10		570	1	11	581	579		591
Oct	10	0	0	10		580	1	11	591	590		601
Nov	10	0	0	10		590	2	11	601	600		611
Dec	10	0	0	10		599	1	10	609	609		619
Jan	10	1	0	10		608	2	10	618	618		628
Feb	9	0	0	9		616	2	10	626	625		635
Mar	9	0	1	10		624	1	10	634	633		644
Apr	10	0	0	10		633	2	10	643	643		653
May	10	0	0	10		641	2	10	651	651		661
Jun	10	0	1	11		649	0	10	659	659		670
Total	10	1	3	13		649	17	125	774	659		787

YEAR 2004-05

Level A					Level B				Combined		
Month	Users	Phase Out	Phase in	Undup.		Users	Phase Out	Phase In	Undup	Grand Total Users	Grand Total Undup
Jul	11	0	0	11		659	1	11	670	670	681
Aug	11	0	0	11		669	2	11	680	680	691
Sep	11	0	1	12		678	1	11	689	689	701
Oct	12	0	0	12		688	1	11	699	700	711
Nov	12	0	0	12		698	2	11	709	710	721
Dec	12	0	0	12		707	1	10	717	719	729
Jan	12	1	0	12		716	2	10	726	728	738
Feb	12	0	1	12		724	2	10	734	736	746
Mar	13	0	0	12		732	1	10	742	745	754
Apr	13	0	0	12		741	2	10	751	754	763
May	13	0	0	12		749	2	10	759	762	771
Jun	13	0	1	13		757	0	10	767	770	780
Total	13	1	3	15		757	17	125	882	770	897

YEAR 2005-06

Level A

Level B

Combined

Month	Users	Phase Out	Phase in	Undup.		Users	Phase Out	Phase In	Undup	Grand Total Users		Grand Total Undup
Jul	13	0	0	13		767	1	11	778	780		791
Aug	13	0	0	13		777	2	11	788	790		801
Sep	13	0	1	14		786	1	11	797	799		811
Oct	14	0	0	14		796	1	11	807	810		821
Nov	14	0	0	14		806	2	11	817	820		831
Dec	14	0	0	14		815	1	10	825	829		839
Jan	14	1	0	14		824	2	10	834	838		848
Feb	13	0	0	13		832	2	10	842	845		855
Mar	13	0	1	14		840	1	10	850	853		864
Apr	14	0	0	14		849	2	10	859	863		873
May	14	0	0	14		857	2	10	867	871		881
Jun	14	0	1	15		865	0	10	875	879		890
Total	14	1	3	17		865	17	125	990	879		1007

Appendix G-2, Methodology for Derivation of Formula Values

FACTOR D

LEVEL OF CARE: **NURSING FACILITY: NF A/B**

The July 25, 1994 final regulation defines Factor D as:

"The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following page.

Assumptions for Factor D have been based on a combination of experience with the *previous* NF waiver and the experience of the Department's *MCOD*. *Factor* D assumes that:

Distribution of Services:

Of the seven beneficiaries under the NF A waiver, none are under the age of 21. The NF B waiver has 98 beneficiaries under the age of 21 (an annual ten percentage increase is estimated for this group of beneficiaries) and 294 over 21. Those under age 21 only receive services under the waiver that are not available under the Early Periodic Screening Diagnosis and Treatment (EPSDT) services.

- Case Management Services – HHA will be provided to: 3 in NF A and 65% of NF B
- Case Management Services - INP will be provided to: 3 in NF A and 15% of NF B
- Case Management Services – ILP will be provided to: 1 in NF A and 10% of NF B
- Case Management Services - PO will be provided to: 1 in NF A and 10% of NF B
- Waiver Service Coordination - 0 in NF A and 8 in NF B
- Personal Care Services - HHA- 0 in NF A and 7% of NF B
- Personal Care Services - Individual Provider (IP) - 1 in NF A and 14% in NF B
- Respite Care – INP will be provided to: 1 in NF A and 12% of NF B
- Respite Care – HHA will be provided to: 1 in NF A and 12% of NF B
- Respite Care - Skilled Nursing Facility providing NF A/B level of care services will be provided to: 0 in NF A and 1% of NF B
- Environmental Accessibility Adaptations will be provided to: 0 in NF A and 1% in NF B
- Personal Emergency Response System will be provided to: 0 in NF A and 7% of NF B
- Private Duty Nursing Services – Registered Nurse (RN)- HHA- will be provided to: 0 in NF A and 4% of NF B
- Private Duty Nursing Services – RN- HHA - Shared - will be provided to: 0 in NF A and 1% of NF B

- Private Duty Nursing Services – RN- INP - will be provided to: 0 in NF A and 6% of NF B
- Private Duty Nursing Services – RN- INP - Shared - will be provided to: 0 in NF A and 3% of NF B
- Private Duty Nursing Services – RN- INP- Supervision - will be 1 in NF A and 3% of NF B
- Private Duty Nursing Services - Licensed Vocational Nurse (LVN) - HHA - 1 in NF A and 14% of NF B
- Private Duty Nursing Services – LVN- HHA- Shared - 0 in NF A and 1% of NF B
- Private Duty Nursing Services - LVN- INP- 1 in NF A and 6% in NF B
- Private Duty Nursing Services - LVN- INP- Shared - 0 in NF A and 3% in NF B
- Private Duty Nursing Services - Certified Home Health Aide (CHHA) - HHA - 1 in NF A and 22% in NF B
- Private Duty Nursing Services - CHHA - HHA - Shared - 1 in NF A and 3% in NF B
- Family Training – HHA will be provided to: 1 in NF A and 1% in NF B
- Family Training – RN-INP will be provided to: 1 in NF A and 1% in NF B
- Utility Coverage – HHA will be provided to: 0 in NF A and 1 in NF B
- Utility Coverage – INP will be provided to: 0 in NF A and 1 in NF B
- Utility Coverage – ILP will be provided to: 0 in NF A and 1 in NF B
- Utility Coverage – PO will be provided to: 0 in NF A and 1 in NF B

COST FACTOR ASSUMPTIONS:

- Costs for Environmental Accessibility Adaptations will be capped at a one-time cost of \$5,000.00.
- Costs for Utility Coverage will be provided to waiver beneficiaries, who are dependent upon medical technology. Life sustaining medical equipment is limited to the following: mechanical ventilation equipment and other respiratory therapy equipment, suction machines, cardiorespiratory monitors, feeding pumps, and infusion equipment. The appropriate MCO staff will determine exceptions to this list if a medical need is determined.

Utility coverage is limited to that portion of the utility bills directly attributable to operation of life sustaining medical equipment in the beneficiary's place of residence. The minimum monthly amount of reimbursement will be \$20.00 a month with a maximum monthly amount of \$75.00. For purposes of completing Appendix G-2, an average of \$45.00 will be used based on historical data. A three per cent cost increase each year is estimated in accordance with the current Consumer Price Index, providing the appropriate State of California funding authorities approve the increases.

- All other services are estimated to increase at three per cent per year in accordance with the current Consumer Price Index, providing the appropriate State of California funding authorities approve the increases.
- Average length of stay will increase each year for each beneficiary at approximately 2.5% per year based on historical data.

APPENDIX G-2 (cont.)Factor DLevel of Care: **Nursing Facility NF A****YEAR 1**

Demonstration of Factor D estimates:

Waiver Services	# of Unduplicated Users	Avg. # Annual Units/Users	Avg. Unit Cost	Total
Case management- Home Health Agency (HHA)	3	48 hours	\$45.43	\$6,542
Case Management -Individual Nurse Provider (INP)	3	48 hours	\$35.77	\$5,151
Case Management - Individual Licensed Professional (ILP)	1	48 hours	\$35.77	\$1,717
Case Management – Professional Organization (PO)	1	48 hours	\$45.43	\$2,181
Waiver Service Coordination	0	48 hours	\$35.77	0
Personal Care Services - HHA	0	3,000 hours	\$10.52	0
Personal Care Services – Individual Provider (IP)	1	3,000 hours	\$9.56	\$28,680
Respite INP-LVN	1	40 hours	\$24.42	\$977
Respite HHA-LVN	1	40 hours	\$29.41	\$1,176
Respite Skilled Nursing Facility (SNF) A/B	0	5 days	\$110.27	0
Environmental Accessibility Adaptations	0	1 event	\$5,000.00	0
Personal Emergency Response Systems (PERS)	0	10 months	\$31.51	0
Private Duty Nursing - RN – HHA	0	1,000 hours	\$40.57	0
Private Duty Nursing - RN - HHA- Shared	0	500 hours	\$44.63	0
Private Duty Nursing - RN – INP	0	1,000 hours	\$31.94	0
Private Duty Nursing -RN- INP- Shared	0	500 hours	\$35.13	0
Private Duty Nursing - RN - INP - Supervision	1	24 hours	\$35.77	\$858
Private Duty Nursing - LVN – HHA	1	500 hours	\$29.41	\$14,705
Private Duty Nursing - LVN- HHA- Shared	0	300 hours	\$32.35	0
Private Duty Nursing - LVN- INP	1	300 hours	\$24.42	\$7,326
Private Duty Nursing - LVN- INP - Shared	0	250 hours	\$26.86	0

Waiver Services	# of Unduplicated Users	Avg. # Annual Units/Users	Avg. Unit Cost	Total
Private Duty Nursing - CHHA - Home Health Aide	1	800 hours	\$18.90	\$15,120
Private Duty Nursing - CHHA - Home Health Aide- Shared	1	400 hours	\$20.79	\$8,316
Family Training - HHA	1	24 hours	\$45.43	\$1,090
Family Training - RN - INP	1	24 hours	\$35.77	\$858
Utility Coverage - HHA	0	10 months	\$45.00	0
Utility Coverage - INP	0	10 months	\$45.00	0
Utility Coverage - ILP	0	10 months	\$45.00	0
Utility Coverage - PO	0	10 months	\$45.00	0
Grand Total				\$94,697
Number of Estimated unduplicated users				8

Factor D: **\$11,837**

Factor D': **\$ 9,471**

Total **\$21,308**

Factor G: **\$24,551**

Factor G': **\$ 1,173**

Total **\$25,724**

Average number of days: 326

APPENDIX G-2 (cont.)Factor DLevel of Care: **Nursing Facility NF B****YEAR 1**

Demonstration of Factor D estimates:

Waiver Services	# of Unduplicated Users	Avg. # Annual Units/Users	Avg. Unit Cost	Total
Case Management - HHA	224	48 hours	\$45.43	\$488,463
Case Management –Individual Nurse Provider	52	48 hours	\$35.77	\$89,282
Case Management – Individual Licensed Professional	34	48 hours	\$35.77	\$58,377
Case Management – Professional Organization	34	48 hours	\$45.43	\$74,142
Waiver Service Coordination	8	48 hours	\$35.77	13,736
Personal Care Services – HHA	33	3,900 hours	\$10.52	\$1,353,924
Personal Care Services - IP	62	3,900 hours	\$9.56	\$2,311,608
Respite INP - LVN	53	40 hours	\$24.42	\$51,770
Respite HHA – LVN	53	40 hours	\$29.41	\$62,349
Respite SNF A/B	4	5 days	\$110.27	\$2,205
Environmental Accessibility Adaptations	1	1 event	\$5,000.00	\$5,000
PERS	33	10 months	\$31.51	\$10,398
Private Duty Nursing - RN – HHA	17	1,200 hours	\$40.57	\$827,628
Private Duty Nursing - RN - HHA - Shared	3	650 hours	\$44.63	\$87,029
Private Duty Nursing - RN – INP	26	1,200 hours	\$31.94	\$996,528
Private Duty Nursing - RN - INP - Shared	13	650 hours	\$35.13	\$296,849
Private Duty Nursing - RN - INP - Supervision	12	24 hours	\$35.77	\$10,302
Private Duty Nursing - LVN – HHA	62	650 hours	\$29.41	\$1,185,223
Private Duty Nursing - LVN - HHA-Shared	6	450 hours	\$32.35	\$87,345
Private Duty Nursing - LVN- INP	26	450 hours	\$24.42	\$285,714
Private Duty Nursing - LVN- INP- Shared	13	325 hours	\$26.86	\$113,484
Private Duty Nursing – CHHA- HHA	99	1,000 hours	\$18.90	\$1,871,100
Private Duty Nursing- CHHA- HHA- Shared	13	500 hours	\$20.79	\$135,135
Family Training - HHA	5	24 hours	\$45.43	\$5,452

Family Training - RN - INP	5	24 hours	\$35.77	\$4,292
Utility Coverage - HHA	1	10 months	\$45.00	\$450
Utility Coverage - INP	1	10 months	\$45.00	\$450
Utility Coverage - ILP	1	10 months	\$45.00	\$450
Utility Coverage - PO	1	10 months	\$45.00	\$450
Grand Total				\$10,429,135
Number of Estimated unduplicated users				442

Factor D: **\$23,595**

Factor D': **\$ 9,471**

Total **\$33,066**

Factor G: **\$35,948**

Factor G': **\$ 1,173**

Total **\$37,121**

Average number of days: 326

APPENDIX G-2 (cont.)Factor DLevel of Care: **Nursing Facility NF A/B Combined****YEAR 1**

Demonstration of Factor D estimates:

Waiver Services	# of Unduplicated Users	Avg. # Annual Units/Users	Avg. Unit Cost	Total
Case Management - HHA	227	48 hours	\$45.43	\$495,005
Case Management –Individual Nurse Provider	55	48 hours	\$35.77	\$94,433
Case Management – Individual Licensed Professional	35	48 hours	\$35.77	\$60,094
Case Management – Professional Organization	35	48 hours	\$45.43	\$76,323
Waiver Service Coordination	8	48 hours	\$35.77	\$13,736
Personal Care Services – HHA	33	3,900 hours	\$10.52	\$1,353,924
Personal Care Services – Individual Provider (IP) ¹	1	3,000 hours	\$9.56	\$28,680
Personal Care Services - IP ²	62	3,900 hours	\$9.56	\$2,311,608
Respite INP - LVN	54	40 hours	\$24.42	\$52,747
Respite HHA - LVN	54	40 hours	\$29.41	\$63,525
Respite SNF A/B	4	5 days	\$110.27	\$2,205
Environmental Accessibility Adaptations	1	1 event	\$5,000.00	\$5,000
PERS	33	10 months	\$31.51	\$10,398
Private Duty Nursing - RN – HHA	17	1,200 hours	\$40.57	\$827,628
Private Duty Nursing - RN - HHA – Shared	3	650 hours	\$44.63	\$87,029
Private Duty Nursing - RN - INP	26	1,200 hours	\$31.94	\$996,528
Private Duty Nursing - RN - INP – Shared	13	650 hours	\$35.13	\$296,849
Private Duty Nursing - RN - INP – Supervision	13	24 hours	\$35.77	\$11,160
Private Duty Nursing - LVN - HHA ³	1	500 hours	\$29.41	\$14,705
Private Duty Nursing - LVN – HHA ⁴	62	650 hours	\$29.41	\$1,185,223

¹ NF A Level of Care¹² NF B Level of Care³ NF A Level of Care⁴ NF B Level of Care

Waiver Services	# of Unduplicated Users	Avg. # Annual Units/Users	Avg. Unit Cost	Total
Private Duty Nursing - LVN - HHA- Shared	6	450 hours	\$32.35	\$87,345
Private Duty Nursing - LVN- INP ⁵	1	300 hours	\$24.42	\$7,326
Private Duty Nursing -LVN- INP ⁶	26	450 hours	\$24.42	\$285,714
Private Duty Nursing -LVN- INP- Shared	13	325	\$26.86	\$113,484
Private Duty Nursing - CHHA - Home Health Aide ⁷	1	800 hours	\$18.90	\$15,120
Private Duty Nursing -CHHA- Home Health Aide ⁸	99	1,000 hours	\$18.90	\$1,871,100
Private Duty Nursing - CHHA - Home Health Aide- Shared ⁹	1	400 hours	\$20.79	\$8,316
Private Duty Nursing -CHHA- Home Health Aide- Shared ¹⁰	13	500 hours	\$20.79	\$135,135
Family Training – HHA	6	24 hours	\$45.43	\$6,542
Family Training - RN – INP	6	24 hours	\$35.77	\$5,150
Utility Coverage – HHA	1	10 months	\$45.00	\$450
Utility Coverage – INP	1	10 months	\$45.00	\$450
Utility Coverage – ILP	1	10 months	\$45.00	\$450
Utility Coverage – PO	1	10 months	\$45.00	\$450
Grand Total				\$10,523,832
Number of Estimated unduplicated users				450

Factor D: **\$23,386**

Factor D': **\$ 9,471**

Total **\$32,857**

Factor G: **\$35,743**

Factor G': **\$ 1,173**

Total **\$36,916**

Average number of days: 326

⁵ NF A Level of Care

⁶ NF B Level of Care

⁷ NF A Level of Care

⁸ NF B Level of Care

⁹ NF A Level of Care

¹⁰ NF B Level of Care

APPENDIX G-2 (cont.)Factor DLevel of Care: **Nursing Facility NF A****YEAR 2**

Demonstration of Factor D estimates:

Waiver Services	# of Unduplicated Users	Avg. # Annual Units/Uses	Avg. Unit Cost	Total
Case Management - Home Health Agency (HHA)	4	48 hours	\$46.79	\$8,984
Case Management -Individual Nurse Provider (INP)	3	48 hours	\$36.84	\$5,305
Case Management - Individual Licensed Professional (ILP)	1	48 hours	\$36.84	\$1,768
Case Management - Professional Organization (PO)	1	48 hours	\$46.79	\$2,246
Waiver Service Coordination	0	48 hours	\$36.84	0
Personal Care Services - HHA	0	3,000 hours	\$10.84	0
Personal Care Services - Individual Provider (IP)	1	3,000 hours	\$9.85	\$29,550
Respite INP-LVN	1	40 hours	\$25.15	\$1,006
Respite HHA-LVN	1	40 hours	\$30.29	\$1,212
Respite Skilled Nursing Facility (SNF) A/B	0	5 days	\$113.58	0
Environmental Accessibility Adaptations	0	1 event	\$5,000.00	0
Personal Emergency Response Systems (PERS)	0	10 months	\$32.46	0
Private Duty Nursing - RN – HHA	0	1,000 hours	\$41.79	0
Private Duty Nursing - RN - HHA- Shared	0	500 hours	\$45.97	0
Private Duty Nursing - RN – INP	0	1,000 hours	\$32.90	0
Private Duty Nursing -RN- INP- Shared	0	500 hours	\$36.18	0
Private Duty Nursing - RN - INP – Supervision	1	24 hours	\$36.84	\$884
Private Duty Nursing - LVN – HHA	1	500 hours	\$30.29	\$15,145
Private Duty Nursing - LVN- HHA- Shared	0	300 hours	\$33.32	0
Private Duty Nursing - LVN- INP	1	250 hours	\$25.15	\$6,288
Private Duty Nursing - LVN- INP – Shared	0	125 hours	\$26.23	0

Waiver Services	# of Unduplicated Users	Avg. # Annual Units/Uses	Avg. Unit Cost	Total
Private Duty Nursing - CHHA - Home Health Aide	1	800 hours	\$19.47	\$15,576
Private Duty Nursing - CHHA - Home Health Aide- Shared	1	400 hours	\$21.41	\$8,564
Family Training - HHA	1	24 hours	\$46.79	\$1,123
Family Training - RN - INP	1	24 hours	\$36.84	\$884
Utility Coverage - HHA	0	10 months	\$46.35	0
Utility Coverage - INP	0	10 months	\$46.35	0
Utility Coverage - ILP	0	10 months	\$46.35	0
Utility Coverage - PO	0	10 months	\$46.35	0
Grand Total				\$98,535
Number of Estimated unduplicated users				9

Factor D: **\$10,948**

Factor D': **\$ 9,755**

Total **\$20,703**

Factor G: **\$25,908**

Factor G': **\$ 1,208**

Total **\$27,116**

Average number of days: 334

APPENDIX G-2 (cont.)Factor DLevel of Care: **Nursing Facility NF B****YEAR 2**

Demonstration of Factor D estimates:

Waiver Services	# of Unduplicated Users	Avg. # Annual Units/Users	Avg. Unit Cost	Total
Case Management - HHA	288	48 hours	\$46.79	\$646,825
Case Management -Individual Nurse Provider	67	48 hours	\$36.84	\$118,477
Case Management - Individual Licensed Professional	44	48 hours	\$36.84	\$77,806
Case Management - Professional Organization	44	48 hours	\$46.79	\$98,820
Waiver Service Coordination	16	48 hours	\$36.84	\$28,293
Personal Care Services – HHA	40	3,900 hours	\$10.84	\$1,691,040
Personal Care Services - IP	77	3,900 hours	\$9.85	\$2,957,955
Respite INP- LVN	66	40 hours	\$25.15	\$66,396
Respite HHA- LVN	66	40 hours	\$30.29	\$79,966
Respite SNF A/B	6	5 days	\$113.58	\$3,407
Environmental Accessibility Adaptations	2	1 event	\$5,000.00	\$10,000
PERS	40	10 months	\$32.46	\$12,984
Private Duty Nursing - RN – HHA	20	1,200 hours	\$41.79	\$1,002,960
Private Duty Nursing - RN - HHA – Shared	4	650 hours	\$45.97	\$119,522
Private Duty Nursing - RN – INP	32	1,200 hours	\$32.90	\$1,263,360
Private Duty Nursing - RN - INP – Shared	16	650 hours	\$36.18	\$376,272
Private Duty Nursing - RN - INP – Supervision	16	24 hours	\$36.84	\$14,147
Private Duty Nursing - LVN – HHA	77	650 hours	\$30.29	\$1,516,015
Private Duty Nursing - LVN - HHA-Shared	8	450 hours	\$33.32	\$119,952
Private Duty Nursing - LVN- INP	32	450 hours	\$25.15	\$362,160
Private Duty Nursing - LVN- INP- Shared	16	325 hours	\$27.67	\$143,884
Private Duty Nursing - CHHA- HHA	120	1,000 hours	\$19.47	\$2,336,400
Private Duty Nursing- CHHA- HHA- Shared	16	500 hours	\$21.41	\$171,280
Family Training - HHA	6	24 hours	\$46.79	\$6,738

Waiver Services	# of Unduplicated Users	Avg. # Annual Units/Users	Avg. Unit Cost	Total
Family Training - RN - INP	6	24 hours	\$36.84	\$5,305
Utility Coverage - HHA	1	10 months	\$46.35	\$464
Utility Coverage - INP	1	10 months	\$46.35	\$464
Utility Coverage - ILP	1	10 months	\$46.35	\$464
Utility Coverage - PO	1	10 months	\$46.35	\$464
Grand Total				\$13,231,820
Number of Estimated unduplicated users				551

Factor D: **\$24,014**

Factor D': **\$ 9,755**

Total **\$33,769**

Factor G: **\$37,936**

Factor G': **\$ 1,208**

Total **\$39,144**

Average number of days: 334

APPENDIX G-2 (cont.)Factor DLevel of Care: **Nursing Facility NF A/B Combined****YEAR 2**

Demonstration of Factor D estimates:

Waiver Services	# of Unduplicated Users	Avg. # Annual Units/Users	Avg. Unit Cost	Total
Case Management - HHA	292	48 hours	\$46.79	\$655,809
Case Management -Individual Nurse Provider	70	48 hours	\$36.84	\$123,782
Case Management - Individual Licensed Professional	45	48 hours	\$36.84	\$79,574
Case Management - Professional Organization	45	48 hours	\$46.79	\$101,066
Waiver Service Coordination	16	48 hours	\$36.84	\$28,293
Personal Care Services - HHA	40	3,900 hours	\$10.84	\$1,691,040
Personal Care Services -Individual Provider (IP) ¹¹	1	3,000 hours	\$9.85	\$29,550
Personal Care Services - IP ¹²	77	3,900 hours	\$9.85	\$2,957,955
Respite INP - LVN	67	40 hours	\$25.15	\$67,402
Respite HHA - LVN	67	40 hours	\$30.29	\$81,178
Respite SNF A/B	6	5 days	\$113.58	\$3,407
Environmental Accessibility Adaptations	2	1 event	\$5,000.00	\$10,000
PERS	40	10 months	\$32.46	\$12,984
Private Duty Nursing - RN - HHA	20	1,200 hours	\$41.79	\$1,002,960
Private Duty Nursing - RN - HHA - Shared	4	650 hours	\$45.97	\$119,522
Private Duty Nursing - RN - INP	32	1,200 hours	\$32.90	\$1,263,360
Private Duty Nursing - RN - INP - Shared	16	650 hours	\$36.18	\$376,272
Private Duty Nursing - RN - INP - Supervision	17	24 hours	\$36.84	\$15,031
Private Duty Nursing - LVN - HHA ¹³	1	500 hours	\$30.29	\$15,145
Private Duty Nursing - LVN - HHA ¹⁴	77	650 hours	\$30.29	\$1,516,015

¹¹ NF A Level of Care¹² NF B Level of Care¹³ NF A Level of Care¹⁴ NF B Level of Care

Waiver Services	# of Unduplicated Users	Avg. # Annual Units/Users	Avg. Unit Cost	Total
Private Duty Nursing - LVN - HHA-Shared	8	450 hours	\$33.32	\$119,952
Private Duty Nursing - LVN- INP ¹⁵	1	250 hours	\$25.15	\$6,288
Private Duty Nursing - LVN- INP ¹⁶	32	450 hours	\$25.15	\$362,160
Private Duty Nursing - LVN- INP- Shared	16	325 hours	\$27.67	\$143,884
Private Duty Nursing - CHHA - Home Health Aide ¹⁷	1	800 hours	\$19.47	\$15,576
Private Duty Nursing - CHHA- HHA ¹⁸	120	1,000 hours	\$19.47	\$2,336,400
Private Duty Nursing - CHHA - Home Health Aide- Shared ¹⁹	1	400 hours	\$21.41	\$8,564
Private Duty Nursing- CHHA- HHA- Shared ²⁰	16	500 hours	\$21.41	\$171,280
Family Training - HHA	7	24 hours	\$46.79	\$7,861
Family Training - RN - INP	7	24 hours	\$36.84	\$6,189
Utility Coverage - HHA	1	10 months	\$46.35	\$464
Utility Coverage - INP	1	10 months	\$46.35	\$464
Utility Coverage - ILP	1	10 months	\$46.35	\$464
Utility Coverage - PO	1	10 months	\$46.35	\$464
Grand Total				\$13,330,355
Number of Estimated unduplicated users				560

Factor D: **\$23,804**
Factor D': **\$ 9,755**
Total **\$33,559**

Factor G: **\$37,744**
Factor G': **\$ 1,208**
Total **\$38,952**

Average number of days: 334

¹⁵ NF A Level of Care

¹⁶ NF B Level of Care

¹⁷ NF A Level of Care

¹⁸ NF B Level of Care

¹⁹ NF A Level of Care

²⁰ NF B Level of Care

APPENDIX G-2 (cont.)Factor DLevel of Care: **Nursing Facility NF A****YEAR 3**

Demonstration of Factor D estimates:

Waiver Services	# of Unduplicated Users	Avg. # Annual Units/Users	Avg. Unit Cost	Total
Case Management - Home Health Agency (HHA)	4	48 hours	\$48.19	\$9,252
Case Management - Individual Nurse Provider (INP)	4	48 hours	\$37.95	\$7,286
Case Management - Individual Licensed Professional (ILP)	1	48 hours	\$37.95	\$1,822
Case Management - Professional Organization (PO)	2	48 hours	\$48.19	\$4,626
Waiver Service Coordination	0	48 hours	\$37.95	0
Personal Care Services - HHA	0	3,000 hours	\$11.17	0
Personal Care Services - Individual Provider (IP)	1	3,000 hours	\$10.15	\$30,450
Respite INP-LVN	2	40 hours	\$25.91	\$2,037
Respite HHA-LVN	2	40 hours	\$31.20	\$2,496
Respite Skilled Nursing Facility (SNF) A/B	0	5 days	\$116.99	0
Environmental Accessibility Adaptations	0	1 event	\$5,000.00	0
Personal Emergency Response Systems (PERS)	0	10 months	\$33.43	0
Private Duty Nursing - RN - HHA	0	1,000 hours	\$43.04	0
Private Duty Nursing - RN - HHA- Shared	0	500 hours	\$47.35	0
Private Duty Nursing - RN - INP	0	1,000 hours	\$33.89	0
Private Duty Nursing -RN- INP- Shared	0	500 hours	\$37.27	0
Private Duty Nursing - RN - INP - Supervision	1	24 hours	\$37.95	\$911
Private Duty Nursing - LVN - HHA	1	500 hours	\$31.20	\$15,600
Private Duty Nursing - LVN- HHA- Shared	0	300 hours	\$34.32	0

Waiver Services	# of Unduplicated Users	Avg. # Annual Units/Users	Avg. Unit Cost	Total
Private Duty Nursing - LVN-INP	1	250 hours	\$25.91	\$6,478
Private Duty Nursing - LVN-INP - Shared	0	125 hours	\$28.50	0
Private Duty Nursing - CHHA - Home Health Aide	1	800 hours	\$20.05	\$16,040
Private Duty Nursing - CHHA - Home Health Aide-Shared	1	400 hours	\$22.05	\$8,820
Family Training - HHA	1	24 hours	\$48.19	\$1,157
Family Training - RN - INP	1	24 hours	\$37.95	\$911
Utility Coverage - HHA	0	10 months	\$47.74	0
Utility Coverage - INP	0	10 months	\$47.74	0
Utility Coverage - ILP	0	10 months	\$47.74	0
Utility Coverage - PO	0	10 months	\$47.74	0
Grand Total				\$107,922
Number of Estimated unduplicated users				11

Factor D: **\$9,811**
Factor D': **\$10,048**
Total **\$19,859**

Factor G: **\$27,326**
Factor G': **\$1,244**
Total **\$28,570**

Average number of days: 342

APPENDIX G-2 (cont.)Factor DLevel of Care: **Nursing Facility NF B****YEAR 3**

Demonstration of Factor D estimates:

Waiver Services	# of Unduplicated Users	Avg. # Annual Units/Users	Avg. Unit Cost	Total
Case Management - HHA	351	48 hours	\$48.19	\$811,905
Case Management -Individual Nurse Provider	81	48 hours	\$37.95	\$147,550
Case Management - Individual Licensed Professional	54	48 hours	\$37.95	\$98,366
Case Management - Professional Organization	54	48 hours	\$48.19	\$124,908
Waiver Service Coordination	24	48 hours	\$37.95	\$43,718
Personal Care Services - HHA	47	3,900 hours	\$11.17	\$2,047,461
Personal Care Services - IP	94	3,900 hours	\$10.15	\$3,720,990
Respite INP-LVN	79	40 hours	\$25.91	\$81,876
Respite HHA-LVN	79	40 hours	\$31.20	\$98,592
Respite SNF A/B	7	5 days	\$116.99	\$4,095
Environmental Accessibility Adaptations	3	1 event	\$5,000.00	\$15,000
PERS	47	10 months	\$33.43	\$15,712
Private Duty Nursing - RN - HHA	24	1,200 hours	\$43.04	\$1,239,552
Private Duty Nursing - RN - HHA - Shared	5	650 hours	\$47.35	\$153,888
Private Duty Nursing - RN - INP	38	1,200 hours	\$33.89	\$1,545,384
Private Duty Nursing - RN - INP - Shared	19	650 hours	\$37.27	\$460,285
Private Duty Nursing - RN - INP - Supervision	19	24 hours	\$37.95	\$17,305
Private Duty Nursing - LVN - HHA	94	650 hours	\$31.20	\$1,906,320
Private Duty Nursing - LVN - HHA-Shared	9	450 hours	\$34.32	\$138,996
Private Duty Nursing - LVN- INP	38	450 hours	\$25.91	\$443,061
Private Duty Nursing - LVN- INP- Shared	19	325 hours	\$28.50	\$175,988
Private Duty Nursing - CHHA- HHA	142	1,000 hours	\$20.05	\$2,847,100
Private Duty Nursing- CHHA- HHA- Shared	19	500 hours	\$22.05	\$209,475
Family Training - HHA	7	24 hours	\$48.19	\$8,096

Waiver Services	# of Unduplicated Users	Avg. # Annual Units/Users	Avg. Unit Cost	Total
Family Training - RN - INP	7	24 hours	\$37.95	\$6,376
Utility Coverage - HHA	1	10 months	\$47.74	\$477
Utility Coverage - INP	1	10 months	\$47.74	\$477
Utility Coverage - ILP	1	10 months	\$47.74	\$477
Utility Coverage - PO	1	10 months	\$47.74	\$477
Grand Total				\$16,363,907
Number of Estimated unduplicated users				659

Factor D:	\$24,831
Factor D':	\$10,048
Total	\$34,879

Factor G:	\$40,011
Factor G':	\$ 1,244
Total	\$41,255

Average number of days: 342

APPENDIX G-2 (cont.)Factor DLevel of Care: **Nursing Facility NF A/B Combined****YEAR 3**

Demonstration of Factor D estimates:

Waiver Services	# of Unduplicated Users	Avg. # Annual Units/Users	Avg. Unit Cost	Total
Case Management - HHA	355	48 hours	\$48.19	\$821,158
Case Management -Individual Nurse Provider	85	48 hours	\$37.95	\$154,836
Case Management - Individual Licensed Professional	55	48 hours	\$37.95	100,188
Case Management - Professional Organization	56	48 hours	\$48.19	129,535
Waiver Service Coordination	24	48 hours	\$37.95	43,718
Personal Care Services - HHA	47	3,900 hours	\$11.17	2,047,461
Personal Care Services -Individual Provider (IP) ²¹	1	3,000 hours	\$10.15	30,450
Personal Care Services - IP ²²	94	3,900 hours	\$10.15	3,720,990
Respite INP-LVN	81	40 hours	\$25.91	83,949
Respite HHA-LVN	81	40 hours	\$31.20	101,088
Respite SNF A/B	7	5 days	\$116.99	4,095
Environmental Accessibility Adaptations	3	1 event	\$5,000.00	15,000
PERS	47	10 months	\$33.43	15,712
Private Duty Nursing - RN - HHA	24	1,200 hours	\$43.04	1,239,552
Private Duty Nursing - RN - HHA - Shared	5	650 hours	\$47.35	153,888
Private Duty Nursing - RN - INP	38	1,200 hours	\$33.89	1,545,384
Private Duty Nursing - RN - INP - Shared	19	650 hours	\$37.27	460,285
Private Duty Nursing - RN - INP - Supervision	20	24 hours	\$37.95	18,216
Private Duty Nursing - LVN - HHA ²³	1	500 hours	\$31.20	15,600
Private Duty Nursing - LVN - HHA ²⁴	94	650 hours	\$31.20	1,906,320
Private Duty Nursing - LVN - HHA-Shared	9	450 hours	\$34.32	138,996
Private Duty Nursing - LVN- INP ²⁵	1	250 hours	\$25.91	\$6,478

²¹ NF A Level of Care²² NF B Level of Care²³ NF A Level of Care²⁴ NF B Level of Care²⁵ NF A Level of Care

Waiver Services	# of Unduplicated Users	Avg. # Annual Units/Users	Avg. Unit Cost	Total
Private Duty Nursing - LVN- INP ²⁶	38	450 hours	\$25.91	\$443,061
Private Duty Nursing - LVN- INP- Shared	19	325 hours	\$28.50	\$175,988
Private Duty Nursing - CHHA - Home Health Aide ²⁷	1	800 hours	\$20.05	\$16,040
Private Duty Nursing - CHHA- HHA ²⁸	142	1,000 hours	\$20.05	\$2,847,100
Private Duty Nursing - CHHA - Home Health Aide- Shared ²⁹	1	400 hours	\$22.05	\$8,820
Private Duty Nursing- CHHA- HHA- Shared ³⁰	19	500 hours	\$22.05	\$209,475
Family Training - HHA	8	24 hours	\$48.19	\$9,252
Family Training - RN - INP	8	24 hours	\$37.95	\$7,286
Utility Coverage - HHA	1	10 months	\$47.74	\$477
Utility Coverage - INP	1	10 months	\$47.74	\$477
Utility Coverage - ILP	1	10 months	\$47.74	\$477
Utility Coverage - PO	1	10 months	\$47.74	\$477
Grand Total				\$16,471,829
Number of Estimated unduplicated users				670

Factor D: **\$25,485**
Factor D': **\$10,048**
Total **\$35,533**
Factor G: **\$39,807**
Factor G': **\$1,244**
Total **\$41,051**
Average number of days: 342

²⁶ NF B Level of Care

²⁷ NF A Level of Care

²⁸ NF B Level of Care

²⁹ NF A Level of Care

³⁰ NF B Level of Care

APPENDIX G-2 (cont.)Factor DLevel of Care: **Nursing Facility NF A****YEAR 4**

Demonstration of Factor D estimates:

Waiver Services	# of Unduplicated Users	Avg. # Annual Units/Users	Avg. Unit Cost	Total
Case Management - Home Health Agency (HHA)	5	48 hours	\$49.64	\$11,914
Case Management -Individual Nurse Provider (INP)	5	48 hours	\$39.09	\$9,382
Case Management - Individual Licensed Professional (ILP)	1	48 hours	\$39.09	\$1,876
Case Management - Professional Organization (PO)	2	48 hours	\$49.64	\$4,765
Waiver Service Coordination	0	48 hours	\$39.09	0
Personal Care Services - HHA	0	3,000 hours	\$11.51	0
Personal Care Services - Individual Provider (IP)	1	3,000 hours	\$10.45	\$31,350
Respite INP-LVN	2	40 hours	\$26.69	\$2,135
Respite HHA-LVN	2	40 hours	\$32.14	\$2,571
Respite Skilled Nursing Facility (SNF) A/B	0	5 days	\$120.50	0
Environmental Accessibility Adaptations	0	1 event	\$5,000.00	0
Personal Emergency Response Systems (PERS)	0	10 months	\$34.43	0
Private Duty Nursing - RN - HHA	0	1,000 hours	\$44.33	0
Private Duty Nursing - RN - HHA- Shared	0	500 hours	\$48.77	0
Private Duty Nursing - RN - INP	0	1,000 hours	\$34.91	0
Private Duty Nursing -RN- INP- Shared	0	500 hours	\$38.39	0
Private Duty Nursing - RN - INP - Supervision	1	24 hours	\$39.09	\$938
Private Duty Nursing - LVN - HHA	1	500 hours	\$32.14	\$16,070
Private Duty Nursing - LVN- HHA- Shared	0	300 hours	\$35.35	0
Private Duty Nursing - LVN- INP	1	250 hours	\$26.69	\$6,673
Private Duty Nursing - LVN- INP - Shared	0	125 hours	\$29.36	0
Private Duty Nursing - CHHA - Home Health Aide	1	800 hours	\$20.65	\$16,520

Private Duty Nursing - CHHA - Home Health Aide- Shared	1	400 hours	\$22.71	\$9,084
Family Training - HHA	2	24 hours	\$49.64	\$2,383
Family Training - RN - INP	2	24 hours	\$39.09	\$1,876
Utility Coverage - HHA	0	10 months	\$49.17	0
Utility Coverage - INP	0	10 months	\$49.17	0
Utility Coverage - ILP	0	10 months	\$49.17	0
Utility Coverage - PO	0	10 months	\$49.17	0
Grand Total				\$117,537
Number of Estimated unduplicated users				13

Factor D:	\$9,041
Factor D':	\$10,349
Total	\$19,390

Factor G:	\$28,884
Factor G':	\$ 1,281
Total	30,165

Average number of days: 351

APPENDIX G-2 (cont.)Factor DLevel of Care: **Nursing Facility NF B****YEAR 4**

Demonstration of Factor D estimates:

Waiver Services	# of Unduplica ted Users	Avg. # Annual Units/Users	Avg. Unit Cost	Total
Case Management - HHA	413	48 hours	\$49.64	\$984,063
Case Management - Individual Nurse Provider	95	48 hours	\$39.09	\$178,250
Case Management - Individual Licensed Professional	64	48 hours	\$39.09	\$120,084
Case Management - Professional Organization	64	48 hours	\$49.64	\$152,494
Waiver Service Coordination	32	48 hours	\$39.09	\$60,042
Personal Care Services - HHA	54	3,900 hours	\$11.51	\$2,424,006
Personal Care Services - IP	109	3,900 hours	\$10.45	\$4,442,295
Respite INP-LVN	92	40 hours	\$26.69	\$98,219
Respite HHA-LVN	92	40 hours	\$32.14	\$118,275
Respite SNF A/B	8	5 days	\$120.50	\$4,820
Environmental Accessibility Adaptations	4	1 event	\$5,000.00	\$20,000
PERS	54	10 months	\$34.43	\$18,592
Private Duty Nursing - RN - HHA	27	1,200 hours	\$44.33	\$1,436,292
Private Duty Nursing - RN - HHA - Shared	5	650 hours	\$48.77	\$158,503
Private Duty Nursing - RN - INP	43	1,200 hours	\$34.91	\$1,801,356
Private Duty Nursing - RN - INP - Shared	22	650 hours	\$38.39	\$548,977
Private Duty Nursing - RN - INP - Supervision	22	24 hours	\$39.09	\$20,640
Private Duty Nursing - LVN - HHA	109	650 hours	\$32.14	\$2,277,119
Private Duty Nursing - LVN - HHA-Shared	11	450 hours	\$35.35	\$174,983
Private Duty Nursing - LVN- INP	43	450 hours	\$26.69	\$516,452
Private Duty Nursing - LVN- INP- Shared	22	325 hours	\$29.36	\$209,924

Private Duty Nursing - CHHA- HHA	168	1,000 hours	\$20.65	\$3,469,200
Private Duty Nursing- CHHA- HHA- Shared	22	500 hours	\$22.71	\$249,810
Family Training - HHA	8	24 hours	\$49.64	\$9,531
Family Training - RN - INP	8	24 hours	\$39.09	7,505
Utility Coverage - HHA	1	10 months	\$49.17	\$492
Utility Coverage - INP	1	10 months	\$49.17	\$492
Utility Coverage - ILP	1	10 months	\$49.17	\$492
Utility Coverage - PO	1	10 months	\$49.17	\$492
Grand Total				\$19,503,400
Number of Estimated unduplicated users				767

Factor D: **\$25,428**

Factor D': **\$10,349**

Total **\$35,777**

Factor G: **\$42,296**

Factor G': **\$ 1,281**

Total **\$43,577**

Average number of days: 351

APPENDIX G-2 (cont.)Factor DLevel of Care: **Nursing Facility NF A/B Combined****YEAR 4**

Demonstration of Factor D estimates:

Waiver Services	# of Unduplicated Users	Avg. # Annual Units/Users	Avg. Unit Cost	Total
Case Management - HHA	418	48 hours	\$49.64	\$995,977
Case Management -Individual Nurse Provider	100	48 hours	\$39.09	\$187,632
Case Management - Individual Licensed Professional	65	48 hours	\$39.09	\$121,960
Case Management - Professional Organization	66	48 hours	\$49.64	\$157,259
Waiver Service Coordination	32	48 hours	\$39.09	\$60,042
Personal Care Services – HHA	54	3,900 hours	\$11.51	\$2,424,006
Personal Care Services -Individual Provider (IP) ³¹	1	3,000 hours	\$10.45	\$31,350
Personal Care Services - IP ³²	109	3,900 hours	\$10.45	\$4,442,295
Respite INP-LVN	94	40 hours	\$26.69	\$100,354
Respite HHA-LVN	94	40 hours	\$32.14	\$120,846
Respite SNF A/B	8	5 days	\$120.50	\$4,820
Environmental Accessibility Adaptations	4	1 event	\$5,000.00	\$20,000
PERS	54	10 months	\$34.43	\$18,592
Private Duty Nursing - RN – HHA	27	1,200 hours	\$44.33	\$1,436,292
Private Duty Nursing - RN - HHA - Shared	5	650 hours	\$48.77	\$158,503
Private Duty Nursing - RN - INP	43	1,200 hours	\$34.91	\$1,801,356
Private Duty Nursing - RN - INP - Shared	22	650 hours	\$38.39	\$548,977
Private Duty Nursing - RN - INP - Supervision	23	24 hours	\$39.09	\$21,578
Private Duty Nursing - LVN - HHA ³³	1	500 hours	\$32.14	\$16,070
Private Duty Nursing - LVN - HHA ³⁴	109	650 hours	\$32.14	\$2,277,119

³¹ NF A Level of Care³² NF B Level of Care³³ NF A Level of Care³⁴ NF B Level of Care

Waiver Services	# of Unduplicated Users	Avg. # Annual Units/Users	Avg. Unit Cost	Total
Private Duty Nursing - LVN - HHA-Shared	11	450 hours	\$35.35	\$174,983
Private Duty Nursing - LVN- INP ³⁵	1	250 hours	\$26.69	\$6,673
Private Duty Nursing - LVN- INP ³⁶	43	450 hours	\$26.69	\$516,452
Private Duty Nursing - LVN- INP- Shared	22	325 hours	\$29.36	\$209,924
Private Duty Nursing - CHHA - Home Health Aide ³⁷	1	800 hours	\$20.65	\$16,520
Private Duty Nursing - CHHA- HHA ³⁸	168	1,000 hours	\$20.65	\$3,469,200
Private Duty Nursing - CHHA - Home Health Aide- Shared ³⁹	1	400 hours	\$22.71	\$9,084
Private Duty Nursing- CHHA- HHA- Shared ⁴⁰	22	500 hours	\$22.71	\$249,810
Family Training - HHA	10	24 hours	\$49.64	\$11,914
Family Training - RN - INP	10	24 hours	\$39.09	\$9,381
Utility Coverage - HHA	1	10 months	\$49.17	\$492
Utility Coverage - INP	1	10 months	\$49.17	\$492
Utility Coverage - ILP	1	10 months	\$49.17	\$492
Utility Coverage - PO	1	10 months	\$49.17	\$492
Grand Total				
Number of Estimated unduplicated users				780

Factor D: **\$25,155**

Factor D': **\$10,349**

Total **\$35,504**

Factor G: **\$42,067**

Factor G': **\$ 1,281**

Total **\$43,348**

Average number of days: 351

³⁵ NF A Level of Care

³⁶ NF B Level of Care

³⁷ NF A Level of Care

³⁸ NF B Level of Care

³⁹ NF A Level of Care

⁴⁰ NF B Level of Care

APPENDIX G-2 (cont.)Factor DLevel of Care: **Nursing Facility NF A****YEAR 5**

Demonstration of Factor D estimates:

Waiver Services	# of Unduplicated Users	Avg. # Annual Units/Users	Avg. Unit Cost	Total
Case Management - Home Health Agency (HHA)	7	48 hours	\$51.13	\$17,180
Case Management -Individual Nurse Provider (INP)	5	48 hours	\$40.26	\$9,662
Case Management - Individual Licensed Professional (ILP)	1	48 hours	\$40.26	\$1,932
Case Management - Professional Organization (PO)	2	48 hours	\$51.13	\$4,908
Waiver Service Coordination	0	48 hours	\$40.26	0
Personal Care Services - HHA	0	3,000 hours	\$11.86	0
Personal Care Services - Individual Provider (IP)	1	3,000 hours	\$10.76	\$32,280
Respite INP-LVN	2	40 hours	\$27.49	\$2,199
Respite HHA-LVN	2	40 hours	\$33.10	\$2,648
Respite Skilled Nursing Facility (SNF) A/B	0	5 days	\$124.12	0
Environmental Accessibility Adaptations	0	1 event	\$5,000.00	0
Personal Emergency Response Systems (PERS)	0	10 months	\$35.46	0
Private Duty Nursing - RN - HHA	0	1,000 hours	\$45.66	0
Private Duty Nursing - RN - HHA- Shared	0	500 hours	\$50.23	0
Private Duty Nursing - RN - INP	0	1,000 hours	\$35.96	0
Private Duty Nursing -RN- INP- Shared	0	500 hours	\$39.54	0
Private Duty Nursing - RN - INP - Supervision	1	24 hours	\$40.26	\$966
Private Duty Nursing - LVN - HHA	1	500 hours	\$33.10	\$16,550
Private Duty Nursing - LVN- HHA- Shared	0	300 hours	\$36.41	0
Private Duty Nursing - LVN- INP	1	250 hours	\$27.49	6,873
Private Duty Nursing - LVN- INP - Shared	0	125 hours	\$30.24	0
Private Duty Nursing - CHHA - Home Health Aide	1	800 hours	\$21.27	17,016

Waiver Services	# of Unduplicated Users	Avg. # Annual Units/Users	Avg. Unit Cost	Total
Private Duty Nursing - CHHA - Home Health Aide- Shared	1	400 hours	\$23.39	9,356
Family Training - HHA	2	24 hours	\$51.13	\$2,454
Family Training - RN - INP	2	24 hours	\$40.26	\$1,932
Utility Coverage - HHA	0	10 months	\$50.65	0
Utility Coverage - INP	0	10 months	\$50.65	0
Utility Coverage - ILP	0	10 months	\$50.65	0
Utility Coverage - PO	0	10 months	\$50.65	0
Grand Total				\$125,956
Number of Estimated unduplicated users				15

Factor D: **\$8,397**
Factor D': **\$10,659**
Total **\$19,056**

Factor G: **\$30,514**
Factor G': **\$ 1,319**
Total **\$31,833**

Average number of days: 360

APPENDIX G-2 (cont.)Factor DLevel of Care: **Nursing Facility NF B****YEAR 5**

Demonstration of Factor D estimates:

Waiver Services	# Unduplica ted Users	Avg. # Annual Units/Users	Avg. Unit Cost	Total
Case Management - HHA	475	48 hours	\$51.13	\$1,165,764
Case Management - Individual Nurse Provider	110	48 hours	\$40.26	\$212,573
Case Management - Individual Licensed Professional	73	48 hours	\$40.26	\$141,071
Case Management - Professional Organization	73	48 hours	\$51.13	\$179,160
Waiver Service Coordination	40	48 hours	\$40.26	\$77,299
Personal Care Services - HHA	61	3,900 hours	\$11.86	\$2,821,494
Personal Care Services - IP	123	3,900 hours	\$10.76	\$5,161,572
Respite INP-LVN	105	40 hours	\$27.49	\$115,458
Respite HHA-LVN	105	40 hours	\$33.10	\$139,020
Respite SNF A/B	9	5 days	\$124.12	\$5,585
Environmental Accessibility Adaptations	5	1 event	\$5,000.00	\$25,000
PERS	61	10 months	\$35.46	\$21,631
Private Duty Nursing - RN - HHA	31	1,200 hours	\$45.66	\$1,698,552
Private Duty Nursing - RN - HHA - Shared	6	650 hours	\$50.23	\$195,897
Private Duty Nursing - RN - INP	49	1,200 hours	\$35.96	\$2,114,448
Private Duty Nursing - RN - INP - Shared	25	650 hours	\$39.54	\$642,525
Private Duty Nursing - RN - INP - Supervision	25	24 hours	\$40.26	\$24,156
Private Duty Nursing - LVN - HHA	123	650 hours	\$33.10	\$2,646,345
Private Duty Nursing - LVN - HHA-Shared	12	450 hours	\$36.41	\$196,614
Private Duty Nursing - LVN- INP	49	450 hours	\$27.49	\$606,155
Private Duty Nursing - LVN- INP- Shared	25	325 hours	\$30.24	\$245,700

Waiver Services	# Unduplica ted Users	Avg. # Annual Units/Users	Avg. Unit Cost	Total
Private Duty Nursing - CHHA- HHA	192	1,000 hours	\$21.27	\$4,083,840
Private Duty Nursing- CHHA- HHA- Shared	25	500 hours	\$23.39	\$292,375
Family Training - HHA	8	24 hours	\$51.13	\$9,817
Family Training - RN - INP	8	24 hours	\$40.26	\$7,730
Utility Coverage - HHA	1	10 months	\$50.65	\$507
Utility Coverage - INP	1	10 months	\$50.65	\$507
Utility Coverage - ILP	1	10 months	\$50.65	\$507
Utility Coverage - PO	1	10 months	\$50.65	\$507
Grand Total				\$22,831,809
Number of Estimated unduplicated users				875

Factor D: **\$26,094**

Factor D': **\$10,659**

Total **\$36,753**

Factor G: **\$44,680**

Factor G': **\$1,319**

Total **\$45,999**

Average number of days: 360

APPENDIX G-2 (cont.)Factor DLevel of Care: **Nursing Facility NF A/B Combined****YEAR 5**

Demonstration of Factor D estimates:

Waiver Services	# of Unduplicated Users	Avg. # Annual Units/Users	Avg. Unit Cost	Total
Case Management - HHA	482	48 hours	\$51.13	\$1,182,944
Case Management –Individual Nurse Provider	115	48 hours	\$40.26	\$222,235
Case Management – Individual Licensed Professional	74	48 hours	\$40.26	\$143,003
Case Management – Professional Organization	75	48 hours	\$51.13	\$184,068
Waiver Service Coordination	40	48 hours	\$40.26	\$77,299
Personal Care Services – HHA	61	3,900 hours	\$11.86	\$2,821,494
Personal Care Services –Individual Provider (IP) ⁴¹	1	3,000 hours	\$10.76	\$32,280
Personal Care Services - IP ⁴²	123	3,900 hours	\$10.76	\$5,161,572
Respite INP-LVN	107	40 hours	\$27.49	\$117,657
Respite HHA-LVN	107	40 hours	\$33.10	\$141,668
Respite SNF A/B	9	5 days	\$124.12	\$5,585
Environmental Accessibility Adaptations	5	1 event	\$5,000.00	\$25,000
PERS	61	10 months	\$35.46	\$21,631
Private Duty Nursing - RN – HHA	31	1,200 hours	\$45.66	\$1,698,552
Private Duty Nursing - RN - HHA – Shared	6	650 hours	\$50.23	\$195,897
Private Duty Nursing - RN – INP	49	1,200 hours	\$35.96	\$2,114,448
Private Duty Nursing - RN - INP - Shared	25	650 hours	\$39.54	\$642,525
Private Duty Nursing - RN - INP - Supervision	26	24 hours	\$40.26	\$25,122
Private Duty Nursing - LVN - HHA ⁴³	1	500 hours	\$33.10	\$16,550
Private Duty Nursing - LVN - HHA ⁴⁴	123	650 hours	\$33.10	\$2,646,345
Private Duty Nursing - LVN - HHA-Shared	12	450 hours	\$36.41	\$196,614
Private Duty Nursing - LVN- INP ⁴⁵	1	250 hours	\$27.49	\$6,873
Private Duty Nursing - LVN- INP ⁴⁶	49	450 hours	\$27.49	\$606,155

⁴¹ NF A Level of Care⁴² NF B Level of Care⁴³ NF A Level of Care⁴⁴ NF B Level of Care⁴⁵ NF A Level of Care⁴⁶ NF B Level of Care

Waiver Services	# of Unduplicated Users	Avg. # Annual Units/Users	Avg. Unit Cost	Total
Private Duty Nursing - LVN- INP- Shared	25	325 hours	\$30.24	\$245,700
Private Duty Nursing - CHHA - Home Health Aide ⁴⁷	1	800 hours	\$21.27	\$17,016
Private Duty Nursing - CHHA- HHA ⁴⁸	192	1,000 hours	\$21.27	\$4,083,840
Private Duty Nursing - CHHA - Home Health Aide- Shared ⁴⁹	1	400 hours	\$23.39	\$9,356
Private Duty Nursing- CHHA- HHA- Shared ⁵⁰	25	500 hours	\$23.39	\$292,375
Family Training - HHA	10	24 hours	\$51.13	\$12,271
Family Training - RN - INP	10	24 hours	\$40.26	\$9,662
Utility Coverage - HHA	1	10 months	\$50.65	\$507
Utility Coverage - INP	1	10 months	\$50.65	\$507
Utility Coverage - ILP	1	10 months	\$50.65	\$507
Utility Coverage - PO	1	10 months	\$50.65	\$507
Grand Total				\$22,957,765
Number of Estimated unduplicated users				890

Factor D: **\$25,795**

Factor D': **\$10,659**

Total **\$36,454**

Factor G: **\$44,439**

Factor G': **\$ 1,319**

Total **\$45,758**

Average number of days: 360

⁴⁷ NF A Level of Care

⁴⁸ NF B Level of Care

⁴⁹ NF A Level of Care

⁵⁰ NF B Level of Care

Appendix G-3, Methods Used to Exclude Payments for Room and Board

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

- A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual (e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

“Not applicable”

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

- B. The following service(s) are furnished in the home of a paid caregiver. (Specify):

“Not applicable”

Attached is an explanation of the method used by the State to exclude Medicaid payment for room and board.

Appendix G-4, Methods Used to Make Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Check one:

- X The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.
- The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

Appendix G-5, Factor D'LOC: **NURSING FACILITY: NF A/B**

NOTICE: On July 25, 1994, HCFA published regulations that changed the definition of Factor D'. The new definition is:

"The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.

The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.

Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

Waiver services to users under the age of 21 years of age are only those services not covered under the authority of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services program pursuant to Section 1905(r) of the Social Security Act (refer to page 2-a).

APPENDIX G-5 (cont.)

FACTOR D' (cont.)

LOC: **NURSING FACILITY: NF A/B**

Factor D' is computed as follows (check one):

- ☐ Based on HCFA Form 2082 (relevant pages attached).
- ☐ Based on HCFA Form 372 for years _____ of waiver # _____, which serves a similar target population.
- ☐ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.
- ☒ Other (specify):

The costs for durable medical equipment (DME) are not included in any waiver rate whereas DME costs are included as part of the long term care rate in the hospital setting.

It is expected that the majority of patients served in the waiver will be have a need for some type of DME.

Based on the past three years expenditures, the average Factor D' for NF A/B Level of Care is \$9,471. A cost of living increase of three percent was added.

Appendix G-6, Factor GLOC: **NURSING FACILITY: NF A/B**

The July 25, 1994 final regulation defines Factor G as:

"The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

_____ Based on institutional cost trends shown by HCFA Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.

_____ Based on trends shown by HCFA Form 372 for years _____ of waiver _____, which reflect costs for an institutionalized population at this LOC. Attached is an explanation of any adjustments made to these numbers.

_____ Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached.

_____ Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.

 X Other (specify):

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G.

As of August 1, 2000, the Medi-Cal daily weighted NF A rate in California is \$75.31.

As of August 1, 2000, the Medi-Cal daily weighted NF B rate in California is \$110.27.

Using the NF A/B daily rates times the average number of days the waiver beneficiary receives services gives a comparable cost if the beneficiary had been institutionalized for the same period of time. The rates for NF A and NF B are then multiplied by the percentage of the waiver population represented by their category to extrapolate a beneficiary cost for comparison. A three percent cost of living adjustment was added.

Appendix G-7, Factor G'LOC: **NURSING FACILITY: NF SUBACUTE**

The July 25, 1994 final regulation defines Factor G' as:

"The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.

The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

If individual respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

Factor G' is computed as follows (check one):

☐ Based on HCFA Form 2082 (relevant pages attached).

☐ Based on HCFA Form 372 for years _____ of waiver # _____, which serves a similar target population.

☐ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

☒ Other (specify):

Based on the past three years expenditures, the average G' is \$1,173, a cost of living adjustment of 3% was added.

Appendix G-8, Demonstration of Cost Neutrality**LOC NURSING FACILITY: NF A and B****CALENDAR****YEAR 1: 2001/2002**

FACTOR D:	<u>\$23,386</u>		FACTOR G:	<u>\$35,743</u>
FACTOR D':	<u>\$9,471</u>		FACTOR G':	<u>\$1,173</u>
TOTAL:	<u>\$32,857</u>	≤	TOTAL:	<u>\$36,916</u>

YEAR 2: 2002/2003

FACTOR D:	<u>\$23,804</u>		FACTOR G:	<u>\$37,744</u>
FACTOR D':	<u>\$9,755</u>		FACTOR G':	<u>\$ 1,208</u>
TOTAL:	<u>\$33,559</u>	≤	TOTAL:	<u>\$38,952</u>

YEAR 3: 2003/2004

FACTOR D:	<u>\$25,485</u>		FACTOR G:	<u>\$39,807</u>
FACTOR D':	<u>\$10,048</u>		FACTOR G':	<u>\$1,244</u>
TOTAL:	<u>\$35,533</u>	≤	TOTAL:	<u>\$41,051</u>

YEAR 4: 2004/2005

FACTOR D:	<u>\$25,155</u>		FACTOR G:	<u>\$42,067</u>
FACTOR D':	<u>\$10,349</u>		FACTOR G':	<u>\$1,281</u>
TOTAL:	<u>\$35,504</u>	≤	TOTAL:	<u>\$43,348</u>

YEAR 5: 2005/2006

FACTOR D:	<u>\$25,795</u>		FACTOR G:	<u>\$44,439</u>
FACTOR D':	<u>\$10,659</u>		FACTOR G':	<u>\$1,319</u>
TOTAL:	<u>\$36,454</u>	≤	TOTAL:	<u>\$45,758</u>

APPENDIX G-8 (cont.)

DEMONSTRATION OF COST NEUTRALITY

LOC NURSING FACILITY: NF A

CALENDAR

YEAR 1: 2001/2002

FACTOR D:	<u>\$11,837</u>		FACTOR G:	<u>\$24,551</u>
FACTOR D':	<u>\$9,471</u>		FACTOR G':	<u>\$1,173</u>
TOTAL:	<u>\$21,308</u>	≤	TOTAL:	<u>\$25,724</u>

YEAR 2: 2002/2003

FACTOR D:	<u>\$10,948</u>		FACTOR G:	<u>\$25,908</u>
FACTOR D':	<u>\$9,755</u>		FACTOR G':	<u>\$1,208</u>
TOTAL:	<u>\$20,703</u>	≤	TOTAL:	<u>\$27,116</u>

YEAR 3: 2003/2004

FACTOR D:	<u>\$9,811</u>		FACTOR G:	<u>\$27,326</u>
FACTOR D':	<u>\$10,048</u>		FACTOR G':	<u>\$1,244</u>
TOTAL:	<u>\$19,859</u>	≤	TOTAL:	<u>\$28,570</u>

YEAR 4: 2004/2005

FACTOR D:	<u>\$9,041</u>		FACTOR G:	<u>\$28,884</u>
FACTOR D':	<u>\$10,659</u>		FACTOR G':	<u>\$1,281</u>
TOTAL:	<u>\$19,390</u>	≤	TOTAL:	<u>\$30,165</u>

YEAR 5: 2005/2006

FACTOR D:	<u>\$8,397</u>		FACTOR G:	<u>\$30,514</u>
FACTOR D':	<u>\$10,659</u>		FACTOR G':	<u>\$1,319</u>
TOTAL:	<u>\$19,056</u>	≤	TOTAL:	<u>\$31,833</u>

APPENDIX G-8 (cont.)

DEMONSTRATION OF COST NEUTRALITY

LOC NURSING FACILITY: NF B

CALENDAR

YEAR 1: 2001/2002

FACTOR D:	<u>\$23,595</u>		FACTOR G:	<u>\$35,948</u>
FACTOR D':	<u>\$9,471</u>		FACTOR G':	<u>\$1,173</u>
TOTAL:	<u>\$33,066</u>	≤	TOTAL:	<u>\$37,121</u>

YEAR 2: 2002/2003

FACTOR D:	<u>\$24,014</u>		FACTOR G:	<u>\$37,936</u>
FACTOR D':	<u>\$9,755</u>		FACTOR G':	<u>\$1,208</u>
TOTAL:	<u>\$33,769</u>	≤	TOTAL:	<u>\$39,144</u>

YEAR 3: 2003/2004

FACTOR D:	<u>\$24,831</u>		FACTOR G:	<u>\$40,011</u>
FACTOR D':	<u>\$10,048</u>		FACTOR G':	<u>\$1,244</u>
TOTAL:	<u>\$34,879</u>	≤	TOTAL:	<u>\$ 41,255</u>

YEAR 4: 2004/2005

FACTOR D:	<u>\$25,428</u>		FACTOR G:	<u>\$42,296</u>
FACTOR D':	<u>\$10,349</u>		FACTOR G':	<u>\$1,281</u>
TOTAL:	<u>\$35,777</u>	≤	TOTAL:	<u>\$43,577</u>

YEAR 5: 2005/2006

FACTOR D:	<u>\$26,094</u>		FACTOR G:	<u>\$44,680</u>
FACTOR D':	<u>\$10,659</u>		FACTOR G':	<u>\$1,319</u>
TOTAL:	<u>\$36,753</u>	≤	TOTAL:	<u>\$45,999</u>